TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

INFED (iron dextran)

Please Fax Completed Form To: **888-898-9113**

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ DEA: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____
City, State, Zip: _____
Plan #: _____
Group #: _____
Phone: _____

RX Card (PBM): _____
BIN: _____ PCN: _____
City, State, Zip: _____
Group #: _____
Phone: _____

CLINICAL INFORMATION

Diagnosis/ ICD 10 Code:

☐ D50.9 Iron deficiency anemia ☐ Other:_____

Lab work:

Serum Ferritin level: _____ TIBC (iron % binding panel): _____ CBC: _____ Other:_____

DRUG ORDERS – may not be needed

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Directions	Quantity/Refills
☐ Infed (iron dextran) 500mg IV ☐ Infed (iron dextran) 1000mg IV	Give a test dose of 25mg IVP over 30- 60 sec. Wait 30 minutes. If no reaction, administer rest of drug in 500ml NS over 2 hours.	Quantity: _____ Refills: _____

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X_____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.