Allergy, Asthma & Immunology Center, P.C.
Infusion Services

www.aaicenter.net
Iftikhar Hussain, MD

Fax Referrals To: (855) 891-2191
Have a Question? (855) 478-1528

VENOFER® (iron sucrose) ORDER FORM

(- Required Fields)*

___ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

_____ New Referral _____ Order Renewal _____ Medication/Order Change
_____ Benefits Verification Only _____ Discontinuation Order

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: M F
ADDRESS:		PHONE:	
WEIGHT: LBS KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

VENOFER ORDER*:

*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: ________________________________

____ (NDD-CKD) 200 mg on 5 different occasions over a 14 day period

Physician Signature* ________________________________ **Date*(Order is Valid for One Year)** ____________________
Infusion will be administered per policy and protocols

REQUIRED DIAGNOSIS:

*Primary Diagnosis:

____ Iron Deficiency Anemia

____ Anemia in CKD (include CD Stage)

Secondary Diagnosis:

____ Non-Dialysis Dependent Chronic Kidney Disease (NDD-CKD)

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocol)

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Clinical/Progress Notes supporting DX

_____ Current Medication List and H&P

Last Infusion/Injection Date: ____________________

STANDING LAB ORDERS: _____ CMP _____ CBC

____ Labs to be drawn by Infusion Center Frequency ________________________________

NOTES/ADDITIONAL COMMENTS:

Locations:

-------Oklahoma-------

___ Tulsa

REVISION DATE- 4/2020