FUSE INFUSION

175MemorialHighway.Suite1-1
NewRochelle,NY
1080

914-460-489
fuse@fuseinfusion.com
914-460-4571

Patient Information

Patient Name:	DOB:	Phone:	Gender: M ☐ F ☐
Patient Address:	Email:	Insurance:	

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ D50.0 Iron Deficiency Anemia Secondary to Blood Loss ☐ D50.8 Other Iron Deficiency Anemias
☐ D50.9 Iron Deficiency Anemia, Unspecified ☐ D63.1 Anemia in Chronic Kidney Disease
☐ Other: Code: _____ Description: _____

Clinical Information:

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation
☐ Patient Weight: _____ lbs / _____ kg ☐ Patient Height: _____ in / _____ cm
☐ Allergies: _____
☐ Therapies Tried and Failed: _____
☐ TB Test: Date: _____ Results: _____ ☐ Hep B Test: Date: _____ Results: _____
☐ Does Patient have non-dialysis dependent chronic kidney disease? ☐ Yes ☐ No
☐ Is patient currently on dialysis? ☐ Yes ☐ No

Lab Orders

☐ CBC ☐ Ferritin ☐ Iron/IBC
☐ Other: _____

Lab Orders to be done by

☐ Oklahoma Infusion Services
☐ Referring Provider

Prescription Information

☐ Injectafer

☐ Dose: 15mg/kg (Patient Weight <50kg) ☐ Give 2 doses at least 7 days apart not to exceed 1500mg
☐ Dose: 750mg (Patient Weight 50kg or more) ☐ Give 2 doses at least 7 days apart not to exceed 1500mg

Pre-Medication Orders

☒ Solu-Cortef 50-100mg SIVP ☒ Benadryl 25mg IV PRN
☒ Tylenol tablet 500-1000mg IV PRN ☐ Other: _____

Standing Orders for Adverse Reactions

☒ Stop infusion and initiate NS bolus ☒ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
☒ Notify supervising physician and ordering provider ☒ Oxygen 2-5L nasal cannula
☒ Solu-Cortef 100mg SIVP signs of adverse reaction ☒ Albuterol 2.5mg inhaled PRN for chest tightness
☒ Benadryl 25mg SIVP for hives or bronchial inflammation ☐ Other: _____

Prescriber Information

Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:

_____ _____
Prescriber's Signature: Date:

By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.

Please fax form to: 405-726-9849