Ferrlecit (sodium ferric gluconate)

Provider Order Form *rev. 1/12/2026*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

☐ NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (2 required – 1 primary, 1 secondary)

Primary Diagnosis Codes (Pick One)

- ☐ D50.0 – Iron deficiency anemia secondary to blood loss
- ☐ D50.9 – Iron deficiency anemia, unspecified
- ☐ D50.8 – Other iron deficiency anemias
- ☐ O99.011 – Anemia complicating pregnancy 1st trimester
- ☐ O99.012 – Anemia complicating pregnancy 2nd trimester
- ☐ O99.013 – Anemia complicating pregnancy 3rd trimester

Secondary Diagnosis Codes (Pick One)

- ☐ K90.9 – Intestinal malabsorption
- ☐ K91.2 – Postsurgical malabsorption
- ☐ T45.4X5D – Adverse effect of iron, subsequent encounter
- ☐ Z87.19 – Personal history of other digestive disease
- ☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

- ☐ Acetaminophen (Tylenol) ☐500mg ☐650mg ☐ 1000mgPO
- ☐ Cetirizine (Zyrtec)☐10mgPO
- ☐ Loratadine (Claritin) 10mgPO
- ☐ Diphenhydramine (Benadryl) ☐25mg ☐50mg ☐ PO ☐ IV
- ☐ Methylprednisolone (Solu-Medrol) ☐40mg ☐125mg IV
- ☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required:

- ☐ Sed Rate
- ☐ Calcium
- ☐ Tb QuantiFERON Gold
- ☐ Hepatitis Panel
- ☐ Other: _____

Therapy Order (Select one):

- ☐ Infuse 125mg IV over 60 minutes
- ☐ Other: _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

☐ **Refills:** ☐ zero ☐6 months ☐12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

Special Instructions:

_____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

_____ _____ _____

Provider Name (Print) *Provider Signature* *Date*