

PATIENT INFORMATION

Referral Status:

New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____ Patient Phone: _____

Patient Address: _____ Patient Email: _____

Allergies: _____ NKDA Weight (kg): _____ Height (cm): _____

Sex: M / F Date of Last Infusion: _____ Next due date: _____

Insurance carrier: _____ PA #: _____ PA date: _____

DIAGNOSIS (Select from list or provide ICD-10 code in space provided)

Iron deficiency anemia Anemia in CKD
 Anemia in neoplastic disease Other Description: _____

THERAPY ADMINISTRATION (Choose one)

DOSING & FREQUENCY

Venofer Dose:

100 mg, 200 mg, 300 mg, 500 mg

Venofer Frequency: (Choose one)

every ___ days for ___ doses
 every ___ weeks for ___ doses

Feraheme Dose & Frequency:

510 mg IV x2 doses (Separated by 3-8 days)
 1020 mg IV x1 dose

Injectafer Dose & Frequency:

Pts over 50kg:
 750 mg IV on day 0 and day 7
 15 mg/kg once (max 1000 mg) = _____ mg
 Pts under 50kg
 15 mg/kg IV = _____ mg on day 0 and day 7

Monoferric Dose & Frequency

Pts over 50kg: 1000mg once
 Pts under 50kg: 20mg/kg IV = _____ mg once

LABORATORY ORDERS

At least one month post last infusion of iron, draw CBC with diff, ferritin, Iron, saturation, TIBC.
 Phosphorus (*indicated with Injectafer*)
 Other:

PRE-MEDICATION ORDERS

Acetaminophen 500mg / 650mg PO
 Cetirizine 10mg PO
 Famotidine 20mg PO / IVP
 Diphenhydramine 25mg / 50mg PO / IVP
 Methylprednisolone 40mg / 125mg IVP
 Other:

NURSING

- Hold infusion and notify provider for history of allergy to IV iron
- Monitor patient for hypersensitivity reaction for 30 minutes post infusion.
- Place patient in reclined or semi-reclined position.
- Use with caution in patients with hypotension (*Feraheme/Venofer*)
- Provide nursing care and post-procedure observation per policy
- In the event of an infusion reaction, per RRMC Infusion Reaction Management policy, the patient may receive:
 - Acetaminophen 1000 mg orally
 - Epinephrine 0.5 mg IM
 - Diphenhydramine 25-50 mg IV push
 - Normal saline IV at 150 mL/hr
 - Methylprednisolone 125 mg IV push

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

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

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval) Required Documentation:

Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with oral iron, Reason for anemia (by indication). **Required Labs:** Kidney function, CBC, Ferritin, Iron, TIBC, Iron saturation, Iron within the last 4 weeks.

Provider Name (print)

Provider Signature

Time

Date

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability

Form # 5507 8/25 Rev. 4/26



White- Patient
Yellow- Medical Records

Patient Label