

PATIENT INFORMATION		PRESCRIBER INFORMATION	
Patient Name: _____		Prescriber Name: _____	
Address: _____		NPI: _____	
City, State, Zip: _____		Address: _____	
Cell: _____	Email: _____	City, State, Zip: _____	
Height _____	Weight _____	Phone: _____ Fax: _____	
Last 4 of SSN: _____ DOB: _____		Contact Person: _____	
Allergies: _____			

PRIMARY DIAGNOSIS	
<input type="checkbox"/> D50.0 Iron Deficiency (Blood Loss Chronic)	<input type="checkbox"/> D63.1 Anemia in Chronic Kidney Disease (Code CKD Stage)
<input type="checkbox"/> D50.1 Sideropenic Dysphagia	<input type="checkbox"/> D63.8 Anemia in Other Chronic Disease (Code Underlying Disease)
<input type="checkbox"/> D50.8 Other Iron Deficiency Anemia	<input type="checkbox"/> D64.81 Antineoplastic Chemotherapy Induced Anemia
<input type="checkbox"/> D63.0 Anemia in Neoplastic Disease (code neoplasm first)	<input type="checkbox"/> ICD-10 CODE: _____

SECONDARY DIAGNOSIS (MUST SELECT ONE)	
<input type="checkbox"/> K51.0 – K51.919 Ulcerative Colitis	<input type="checkbox"/> N92.5 Other unspecified irregular menstruation
<input type="checkbox"/> K90.0 Celiac Disease	<input type="checkbox"/> N92.6 Irregular menstruation, unspecified
<input type="checkbox"/> K90.4 Malabsorption due to intolerance, not elsewhere classified	<input type="checkbox"/> N18.1-N18.6. ____ Stage Chronic Kidney Disease
<input type="checkbox"/> K90.9 Intestinal malabsorption unspecified, KN18	<input type="checkbox"/> ICD-10 CODE: _____
<input type="checkbox"/> N92.0 Excessive and frequent menstruation with regular cycle	

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Documentation of failure of oral iron or iron intolerance
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and tests supporting primary diagnosis
<input type="checkbox"/> CBC and Iron Panel (within 30 days)	

PRESCRIBING INFORMATION			
Medication	Dose/Strength	Directions	Quantity
<input type="checkbox"/> Iron Sucrose (Venofer)	100 mg/5 mL	<input type="checkbox"/> Infuse 200 mg in 0.9% NS 100 mL IV over 30 minutes every 2 days x 5 doses	5 doses (10 vials)
		<input type="checkbox"/> Infuse 200 mg in 0.9% NS 100 mL IV over 30 minutes every 7 days x 5 doses	5 doses (10 vials)
		<input type="checkbox"/> Infuse 300 mg in 0.9% NS 250 mL IV over 90 minutes every 3 days x 3 doses	3 doses (9 vials)
		<input type="checkbox"/> Infuse 500 mg in 0.9% NS 250 mL IV over 3.5 hours every 7 days x 2 doses	2 doses (10 vials)
<input type="checkbox"/> Ferumoxytol (Feraheme)	510 mg/17 mL	<input type="checkbox"/> Infuse 510 mg (17mL) in 0.9% NS 100 mL IV over 30 minutes x 1 dose	1 dose (1 vial)
		<input type="checkbox"/> Infuse 510 mg (17 mL) in 0.9% NS 100 mL IV over 30 minutes every 7 days x 2 doses	2 doses (2 vials)
<input type="checkbox"/> (Ferric Carboxymaltose) (Injectafer)	750 mg/ 15 mL	<input type="checkbox"/> Infuse 750 mg in 0.9% NS 250 mL IV over 30 minutes every 7 days x 2 doses	2 doses (2 vials)
		<input type="checkbox"/> If <50kg, infuse 15 mg/kg, (max dose 750 mg) in 0.9% NS 250 mL IV over 30 minutes every 7 days x 2 doses	2 doses (2 vials)
<input type="checkbox"/> Acetaminophen	650 mg	650 mg po prior to infusion	
<input type="checkbox"/> Diphenhydramine	25 mg	25 mg po prior to infusion	
NS 0.9% 10 mL		For PIV flush 3-10 mL NS before and after	
Heparin 10 units/mL		For PICC/Midline flush 10 mL NS before/after, then 3 mL Heparin 10 units/mL final flush	
Heparin 100 units/mL		For Port flush 10 mL NS before/after, then 5 mL Heparin 100 units/mL final flush	
NS 0.9% 50 mL bag		Flush residual priming volume post infusion	

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline

RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration

RN to flush and lock VAD/CVAD per company protocol

Other: _____

EMERGENCY MEDICATION

Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (>40 kg): Diphenhydramine 25–50 mg PO or IV slow push (2–5 min); Acetaminophen 325–650 mg PO; Methylprednisolone 125 mg IV slow push (≥5 min); Epinephrine 0.3 mg IM/SQ, may repeat ×1; 0.9% NS 500 mL IV over 30–60 min, may repeat ×1 for hypotension.

Pediatrics (<40 kg): Diphenhydramine 25 mg PO or IV slow push (2–5 min); Acetaminophen 325 mg PO; Methylprednisolone 40 mg IV slow push (≥5 min); Epinephrine 0.15 mg (<30 kg) or 0.3 mg (>30 kg) IM/SQ, may repeat ×1; 0.9% NS 500 mL IV over 30–60 min, may repeat ×1 for hypotension.

Oxygen (AIC/AIS only): 1–6 L/min via NC or face mask; titrate to maintain SpO₂ 95–100%.

Prescriber Signature X: _____

Product Substitution Permitted: _____ Date: _____

X: _____

Dispense as Written: _____ Date: _____