

IV IRON REPLACEMENT THERAPY

Status	<input type="checkbox"/> New Therapy <input type="checkbox"/> Order Renewal <input type="checkbox"/> Dosage or Frequency Change			
Diagnosis	<input type="checkbox"/> ICD 10 Code: D50.____ Iron Deficiency Anemia <input type="checkbox"/> ICD 10 Code: N18.____ Chronic Kidney Disease (CKD) <input type="checkbox"/> ICD 10 Code: _____ Other: _____			
Pertinent Medical Hx	Patient's weight (most recent): _____ lbs / kg (circle one) Date: _____ Intolerance or unsatisfactory response to oral iron? (Provide documentation) <input type="checkbox"/> Y <input type="checkbox"/> N			
Labs	Hemoglobin: _____ Date: _____ Hematocrit: _____ Date: _____ Labs to be drawn by: <input type="checkbox"/> Infusion Clinic <input type="checkbox"/> Referring Physician If Infusion Clinic: _____			
Premeds	<input type="checkbox"/> No premeds necessary <input type="checkbox"/> acetaminophen (Tylenol) <input type="checkbox"/> 500mg / <input type="checkbox"/> 650mg / <input type="checkbox"/> 1000mg PO <input type="checkbox"/> cetirizine (Zyrtec) 10mg PO - OR - <input type="checkbox"/> diphenhydramine (Benadryl) 25mg PO <input type="checkbox"/> other: _____			
IV Fluids	<input type="checkbox"/> NS TKO <input type="checkbox"/> Other: _____			
Medication Order	<input type="checkbox"/> Injectafer (ferric carboxymaltose) 750mg IV x 2 doses, separated by at least 7 days (Based on payer guidelines, Venofer may be substituted for Injectafer.) <input type="checkbox"/> Venofer (iron sucrose) _____ mg IV x _____ doses <input type="checkbox"/> Feraheme (ferumoxytol) 510mg IV x 2 doses, separated by 3-8 days. <input type="checkbox"/> Infed (iron dextran) _____ mg IV over 4 hours. Test dose of 25mg/50ml IV over 15-30 minutes. If no reaction after 30-60 minutes, then give remainder of dose. <input type="checkbox"/> Other: _____			
Monitoring	Monitor for signs/symptoms of hypersensitivity during infusion and 30 mins post-infusion. For any signs of infusion reaction: STOP infusion. Contact on-site provider for instruction.			
Additional Orders	 			
Physician Information	Physician Name	_____	NPI	_____
	Office Contact	_____	Phone	_____
	Provider Signature:	_____	Date	_____

Patient Name
 DOB
 Address
 Cell Phone

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REQUIRED DOCUMENTATION	
o Patient Demographics & Insurance Information:	- Copy of patient's insurance card – front and back
o Clinical / Progress Notes, supporting primary diagnosis:	- 2 most recent office notes - Medication history
o Most Recent Labs:	- CMP and CBC - Hemoglobin/Hematocrit w/in last 30 days - Other iron studies as available: Serum iron, (TIBC) total iron binding capacity, serum ferritin and transferrin saturation within last 30 days.

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