

IRON INFUSION ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (circle)

Allergies: _____

Primary ICD-10: _____

Secondary ICD-10: _____

- Iron Deficiency Anemia
- Iron Deficiency Unspecified
- Iron Deficiency Anemia secondary to Inadequate Dietary Iron Intake
- Other medical necessity: _____

- Adverse effect of other drug (oral iron intolerance or not adequate)
- End-Stage Renal Disease
- Intestinal Malabsorption
- Chronic Kidney Disease
- Other medical necessity: _____

INFED THERAPY ORDER

- Infed 1000 mg IV** x 1 dose
- Infed _____ mg IV** x 1 dose
- Infed _____ mg/kg IV** x 1 dose

*** Administer 25 mg test dose over at least 30 seconds, wait 1 hour before administering the remaining dose***

INJECTAFER THERAPY ORDER

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Patient weighing less than 50kg (110 lbs.)
Dose: Injectafer 15mg/kg IV
Frequency: Give 2 doses at least 7 days apart
Not to exceed 1500mg | <input type="checkbox"/> Patient weighing 50kg (110 lbs.) or greater
Dose: Injectafer 750mg IV
Frequency: Give 2 doses at least 7 days apart not to exceed 1500 mg |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

MONOFERRIC THERAPY ORDER

- | | |
|--------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Patient weighing less than 50kg (110 lbs.)
Dose: Monoferric 20mg/kg IV x 1 dose | <input type="checkbox"/> Patient weighing 50kg (110 lbs.) or greater
Dose: Monoferric 1000mg IV x 1 dose |
|--------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
 - >30 kg (>66lbs.): 0.3mg IM or subQ; may repeat in 5-10 minutes x 1
 - 15-30 kg (33-66lbs.) 0.15mg IM or subQ; may repeat in 5-10 minutes x 1
- Solu-Medrol 125mg IV as needed
- NS 250-500mL IV bolus as needed

Flush Orders: NS 1-20mL pre/post infusion PRN

Please provide patient's demographic information, insurance information, medication list, and clinical notes. City Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

COMPREHENSIVE SUPPORT FOR IRON INFUSION ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL AND INSURANCE APPROVAL

- Include signed and completed order (MD/prescriber to complete previous page)
- Include patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes (H&P) to support primary diagnosis
 - Does the patient have an intolerance, contraindication, or documented tried and failed use of oral iron?
 Yes No
If yes, which drug(s)? _____
 - Does the patient have an intolerance or documented tried and failed use of an IV iron product?
 Yes No
If yes, which drug(s)? _____
- Labs showing iron deficiency anemia attached
- Other medical necessity: _____

OTHER NOTES
