

Phone: 800-809-1265

MRN: _____

DOB: _____

Standard Plan of Treatment for Feraheme

(Re)Certification Period from _____ to _____

Note: We may require MD office notes and may require a letter of Medical Necessity (depending on diagnosis), to be able to verify eligibility and payment for this treatment through patients Medicare and/or other insurance plan.

Patient's Name _____ HT: _____ Weight: _____ Allergies: _____

Primary Diagnosis:

- Iron deficiency Anemia related to CKD, non-ESRD
 Other: _____

Orders:

Obtain weight each visit. Vital Signs before and after IVP, then 30 minutes after IVP completed. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient response to therapy. Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn Normal Saline Flush 5 ml before and after infusion followed by Heparin Lock 1-5ml 100 units/ml as needed per line type. Tubing and/or supplies needed to complete prescribed therapy.

If adverse drug reaction, Implement the Standing Adverse Reaction protocol.

Monitor patient for 30 minutes prior to each IVP completion.

Dose:

Initial dose: Feraheme 510mg IVP over 17-20 seconds (1ml/sec)

Second dose: Feraheme 510mg IVP over 17-20 seconds (1ml/sec) 3 to 8 days after the initial dose

Other:

Pharmacist to perform clinical drug monitoring

(No Stamped Signatures Please)

Physicians Signature: _____ Date: _____
(Dispense as written) (Substitution Permitted)

Print Physician Name: _____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO 866-872-8920