Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Iron Replacement Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:	
Patient Name:		Address:	
Date of Birth:		City, State, Zip:	
Height in inches:	Weight: LB or KG	Gender:	Allergies: ☐ See list ☐ NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	D50.9 - Iron deficiency Anemia	☐	_____.___ Secondary Diagnosis **(REQUIRED)**
☐	D50.0 - Iron deficiency anemia secondary to blood loss (chronic)		
☐	_____ - Other:		

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	Hemoglobin and Hematocrit within 30 days		☐ **Continue current order until insurance approved**
6	Other iron studies as available		

☐ **Pharmacist to dose:** Check preferred products below and the **pharmacist will dose according to FDA package labeling**. This requires the provider to send Hemoglobin and Hematocrit levels within last 30 days

MEDICATION ORDERS:

We may require a Letter of Medical Necessity (depending on diagnosis) in order to verify eligibility and payment for this treatment through the patients Medicare and/or other insurance plan

Premedication:_____

☐ **Injectafer® (ferric carboxymaltose):** Diluted in 100-250ml NS given IV over at least 30 minutes via pump
Weight less than 50 kg: 2 doses of 15mg/kg will be given IV separated by at least 7 days
Weight of 50 kg or more: 2 doses of 750mg will be given IV separated by at least 7 days

☐ **Monoferric® (ferric derrisomaltose):** Diluted in 100-500ml NS given IV over at least 20 minutes via pump
Weight less than 50 kg: Administer 20mg/kg IV via pump as a single dose
Weight 50 kg or more: Administer 1000mg IV via pump as a single dose

☐ **Infed® (iron dextran):** _____mg IV to be diluted in 250-500ml of NS over 4 hours.
☐ One time dose ☐ Frequency:_____
Test dose of 25mg/50 ml of NS given IV over 15-30 minutes at pharmacist discretion per protocol. Administer remaining dose 60 minutes after completion of test dose if tolerated.

☐ **Feraheme® (feruoxytol) Injection:** Diluted in 250ml NS given IV over at least 30 minutes via pump
Initial dose of 510mg followed by second 510mg dose 3-8 days later

If initial selection is not covered by insurance, the following products may be used as alternatives

PHARMACIST TO DOSE MUST BE SELECTED TO USE ALTERNATIVE

Rank	Alternative product
1st	
2nd	
3rd	

☐ **Venofer® (iron Sucrose):** _____mg IV diluted in 100-250ml NS over 1 - 4 hours per protocol
Frequency:_____
Only indicated for chronic kidney disease

☐ **Ferrlecit® (sodium ferric gluconate):** _____mg IV via pump in 100ml NS over 1-2 hours
Frequency:_____
Test dose of 25mg/50 ml of NS given IV over 15-30 minutes at pharmacist discretion per protocol
Only indicated for chronic kidney disease

Follow each infusion with a 30 minute post observation

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC
☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	

Checklist for referrals to AccuRX Infusion:

Fax referral to 1.866.990.3192

- ☐ **Patient demographics – address, phone number, SS#, etc.**
- ☐ **Insurance Information – copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

www.AccuRXInfusion.com

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