

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> 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:
<input type="checkbox"/> See list	<input type="checkbox"/> NDKA

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

D50.9 - Iron deficiency Anemia
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	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5	Hemoglobin and Hematocrit within 30 days	THERAPY:	
6	Other iron studies as available		
			Continue current order until insurance approved

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 <u>Weight less than 50 kg:</u> 2 doses of 15mg/kg will be given IV separated by at least 7 days <u>Weight of 50 kg or more:</u> 2 doses of 750mg will be given IV separated by at least 7 days	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								
Monofer® (ferric dextran): Diluted in 100-500ml NS given IV over at least 20 minutes via pump <u>Weight less than 50 kg:</u> Administer 20mg/kg IV via pump as a single dose <u>Weight 50 kg or more:</u> 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 <input type="checkbox"/> One time dose <input type="checkbox"/> Frequency: _____ Test dose of 25mg/50 ml of NS given IV over 15-30 minutes at pharmacist discretion per protocol									
Feraheme® (feroxytol) 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	<table border="1"> <tr> <th>Rank</th> <th>Alternative product</th> </tr> <tr> <td>1st</td> <td></td> </tr> <tr> <td>2nd</td> <td></td> </tr> <tr> <td>3rd</td> <td></td> </tr> </table>	Rank	Alternative product	1 st		2 nd		3 rd	
Rank	Alternative product								
1 st									
2 nd									
3 rd									
Venofer® (iron Sucrose): _____ mg IV diluted in 100-250ml NS over 1 - 4 hours per protocol Frequency: _____	Only indicated for chronic kidney disease								
Ferlecit® (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
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