

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 2<sup>ND</sup> AND 3<sup>RD</sup> 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	<b>IF ORDER CHANGE:</b>
5	Hemoglobin and Hematocrit within 30 days	THERAPY:	
6	Other iron studies as available		
			<b>Continue current order until insurance approved</b>

**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: \_\_\_\_\_

<b>Injectafer® (ferric carboxymaltose):</b> 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	<b>If initial selection is not covered by insurance, the following products may be used as alternatives</b>  PHARMACIST TO DOSE MUST BE SELECTED TO USE ALTERNATIVE								
<b>Monofer® (ferric dextran):</b> 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									
<b>Infed® (iron dextran):</b> _____ 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									
<b>Feraheme® (feroxytol) Injection:</b> 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>1<sup>st</sup></td> <td></td> </tr> <tr> <td>2<sup>nd</sup></td> <td></td> </tr> <tr> <td>3<sup>rd</sup></td> <td></td> </tr> </table>	Rank	Alternative product	1 <sup>st</sup>		2 <sup>nd</sup>		3 <sup>rd</sup>	
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2 <sup>nd</sup>									
3 <sup>rd</sup>									
<b>Venofer® (iron Sucrose):</b> _____ mg IV diluted in 100-250ml NS over 1 - 4 hours per protocol Frequency: _____	Only indicated for chronic kidney disease								
<b>Ferlecit® (sodium ferric gluconate):</b> _____ 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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# Palmetto

## INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- 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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

[www.PalmettoInfusion.com](http://www.PalmettoInfusion.com)