aleracare
advanced infusion centers™

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Iron (Feraheme, Injectafer, Monoferric, Venofer)

Provider Order Form rev. 5/5/2023

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable): _____

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

ICD-10 CODE

◯ D64.9 Anemia unspecified (includes Anemia due to medications)

◯ D63.1 Anemia in chronic kidney disease (select secondary code to indicate type of CKD)

- ◯ N18.30 CKD, stage 3 unspecified
- ◯ N18.5 CKD, stage 5
- ◯ N18.4 CKD, stage 4
- ◯ N18.6 End stage renal disease

◯ Other: _____

Medication Order

Feraheme (ferumoxytol)
Dose: ◯ 510mg IV
Frequency: ◯ One dose followed by a second dose 3 to 8 days later ◯ Other: _____

Injectafer (ferric carboxymaltose)
Dose: ◯ 15mg/kg IV ◯ 750mg IV ◯ Other: _____
Frequency: ◯ Give twice, first and second dose are separated by at least 7 days ◯ Give twice. First dose is on day 0 and second dose is on day _____ ◯ Other: _____

Monoferric (ferric derisomaltose)
Dose: ◯ 1,000mg IV ◯ 20mg/kg IV ◯ Other: _____
Frequency: ◯ Once ◯ Other: _____

Venofer (iron sucrose)
Dose: ◯ 100mg IV ◯ 400mg IV ◯ 200mg IV ◯ 0.5mg/kg ◯ 300mg IV
Frequency: ◯ Once ◯ Other: _____
Route: ◯ Slow IV Push ◯ Infusion

Documentation Required (Note: Send all labs, must include specific labs listed here)

◯ Labs (Iron) ◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

Pre-Medication Order

acetaminophen (Tylenol) ◯ 500mg ◯ 650mg ◯ 1000mg PO

cetirizine (Zyrtec) ◯ 10mg PO

loratadine (Claritin) ◯ 10mg PO

diphenhydramine (Benadryl) ◯ 25mg ◯ 50mg / ◯ PO ◯ IV

methylprednisolone (Solu-Medrol) ◯ 40mg IV ◯ 125mg IV

hydrocortisone (Solu-Cortef) ◯ 100mg IV

Other: _____

Dose:_____ Route:_____ Frequency: _____

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

_____

Provider Name _____ **Provider Signature** _____ **Date** _____

Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order ◯