

Iron Infusion

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVE Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

Patient Name: _____ Patient Address: _____ Patient Phone Number: _____ Date of Birth: ____/____/____ Weight: ____ kg Height: ____ cm Allergies: _____		Primary Insurance: _____ Member ID: _____ Secondary Insurance: _____ Member ID: _____	
Diagnosis <input type="checkbox"/> Iron Deficiency Anemia (D50.9) <input type="checkbox"/> Other Diagnosis Code (ICD-10): _____ Is the patient on hemodialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No Did the patient have an inadequate response to oral iron supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No Target start date: _____		Labs <input type="checkbox"/> CBC <input type="checkbox"/> Iron Studies (Iron, T-sat, TIBC, Ferritin) <input type="checkbox"/> Phosphorus <input type="checkbox"/> Other: _____ Hemoglobin: _____ Date: _____ Ferritin: _____ Date: _____	
Iron Product Selection			
Ferumoxytol (Feraheme) – TH Tier 1 Preferred Therapy <input type="checkbox"/> 510 mg IV over 15 minutes weekly x 2 doses <input type="checkbox"/> 510 mg IV over 30 minutes weekly x 2 doses <input type="checkbox"/> Other: _____		Iron Sucrose (Venofer) – TH Tier 1 <input type="checkbox"/> 100 mg IV push every 4 weeks <input type="checkbox"/> 200 mg IV push 3 times weekly x 5 doses <input type="checkbox"/> 200 mg IV push weekly x 5 doses <input type="checkbox"/> 300 mg IV infusion every 2 weeks x 2 doses -followed by- 400 mg IV infusion x 1 dose <input type="checkbox"/> Other: _____ Dose _____ mg Sig _____ Total # of Doses _____	
Ferric Carboxymaltose (Injectafer) – TH Tier 2 <i>Non-preferred – must answer one of the first two boxes in addition to selecting dose</i> <input type="checkbox"/> Intolerance to other IV iron products -OR- <input type="checkbox"/> Insurance authorization requires use for treatment -AND- <input type="checkbox"/> 750 mg IV push weekly x 2 doses <input type="checkbox"/> 15 mg/kg IV push weekly x 2 doses (if < 50 kg) <input type="checkbox"/> Other: _____		Sodium Ferric Gluconate (Ferrlecit) – TH Tier 1 <input type="checkbox"/> 125 mg IV infusion 3 times weekly x 8 doses <input type="checkbox"/> Other: _____	

Pre-Medications and Pre-Protocol (ordered at physician discretion)	<input type="checkbox"/> Acetaminophen 650 mg PO once <input type="checkbox"/> Loratadine 10 mg PO once <input type="checkbox"/> Diphenhydramine once <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Famotidine 20 mg IV once <input type="checkbox"/> Hydrocortisone 100 mg IV once <input type="checkbox"/> Methylprednisolone 125 mg IVP once <input type="checkbox"/> Other: _____	Hydration <input type="checkbox"/> LR <input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> Other _____ _____ mL at _____ mL/hr <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> Following
Flushing Protocol <i>as needed for line care</i>	Sodium Chloride 0.9% 5 mL 10 mL	Heparin 100 Units/mL 5 mL 10 mL
Hypersensitivity Panel Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary	<ul style="list-style-type: none"> • Sodium chloride 0.9% bolus 500 mL once as needed for hypotensive management (SBP <90mmHg) • Acetaminophen 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping • Albuterol 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses • Albuterol HFA inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea • Epinephrine injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses • Famotidine injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Diphenhydramine injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom • Diphenhydramine injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Hydrocortisone sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure 	
<div> <div> Provider Name: _____ </div> <div> Provider Signature: _____ </div> </div> <div> <div> Attending Physician Name: _____ </div> <div> Provider NPI: _____ </div> </div> <div> <div> Office Phone Number: _____ </div> <div> Office Fax Number: _____ </div> </div> <p><i>Note: This order is valid for 12 months from date of physician signature.</i></p>		