Iron Infusion (Feraheme, Venofer, Monoferric)

Provider Order Form rev. 2/14/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Select from list or provide ICD-10 code in space provided)*

☐ D50.0: iron deficiency secondary to blood loss ☐ D50.8: Other iron deficiency Anemia

☐ D63.0: Anemia in neoplastic disease ☐ D63.1: Anemia in CKD ☐ E83.10: Disorder of iron metabolism, unspecified

Other: Description:

THERAPY ADMINISTRATION *(Choose one)*

☐ Infuse iron product as required by patient's insurance.
List in order of preference: _____, _____, _____

☐ Infuse this product only (subject to prior authorization)

_____

DOSING & FREQUENCY

Venofer Dose: ☐ 100mg, ☐ 200mg, ☐ 300mg IV. Mix 100mg and 200mg in 100ml NS and infuse over 15min. Mix 300mg in 250mg NS and infuse over 90min.

Venofer Frequency: *(Choose one)*

☐ every _____days for _____doses
☐ every _____weeks for _____doses

Feraheme Dose & Frequency:

☐ administer 510mg IV x2 doses (Separated by 3-8 days). Mix in 100ml NS and infuse over 15-30 minutes.

Monoferric Dose & Frequency

☐ Pts over 50kg, administer 1000mg IV over at least 20min as single dose. Dilute in 100ml NS

☐ Pts under 50kg, administer 20mg/kg IV = _____mg over at least 20mins as single dose. Dilute to final concentration of 1mg/ml

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO
☐ Loratadine 10mg PO
☐ Pepcid 20mg ☐ PO / ☐ IVP
☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
☐ Solumedrol ☐ 40mg / ☐ 125mg IVP
☐ Other: _____

NURSING

☑ Hold infusion and notify provider for history of allergy to IV iron
☑ Monitor patient for hypersensitivity reaction for 30 minutes post infusion.
☑ Place patient in reclined or semi-reclined position.
☑ Use with caution in patients with hypotension *(feraheme/venofer)*
☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with oral iron, Reason for anemia (by indication)

Required Labs: Kidney function, CBC with diff and iron studies (iron, ferritin, transferrin, TIBC and saturation) within the last 4 weeks.

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.