☐ *Borough Park*
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ *Crown Heights*
555 Lefferts Avenue
Brooklyn, NY 11225

☐ *Manhattan*
57W 57Street
Suite 601
New York, NY 10019

☐ *Manhasset*
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ *Rockville Centre*
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ *Elmsford/ Terrytown*
555 Taxter Road
3rd Floor
Elmsford, NY 10523

☐ *NYC Central Park West*
115 Central Park West
Suite 15
New York, NY 10023

☐ *Woodbury*
75 Froehlich Farm
Woodbury, NY 11797

☐ *Staten Island*
27 New Dorp Lane
Staten Island, NY 10306

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

☐ *Manhattan*
225 E 70th Street
Suite 1E
New York, NY 10021

☐ *Holbrook/ Ronkonkoma*
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ *Long Beach*
917 Beech Street
Long Beach, NY 11561

☐ *Queens*
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ *Scarsdale*
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

☐ *Riverhead*
1228 E Main Street
Suite A
Riverhead, NY 11901

☐ *Manhattan*
225 East 70th Street
New York, NY 10021

☐ *5 Towns*
141 Washington Avenue
Cedarhurst, NY 11559

☐ *Bronx*
226 West 238th Street
Bronx, NY 10463

Provider Order Form

Iron (Feraheme/Injectafer/Venofer) Date: _____

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

ICD-10 code (required): ICD -10 description:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

REFERRAL STATUS: ☐ New Prescription ☐ Order Renewal ☐ Does or Frequency Change ☐ Discontinuation

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

PREN-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐500mg / ☐650mg / ☐1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐50mg ☐PO / ☐IV
☐ methylprednisolone (Solu-Medrol) ☐40mg / ☐125mg IV
☐ Other:_____
Dose:_____ Route: _____
Frequency:_____

SPECIAL INSTRUCTIONS

_____

*Closely observe patients for signs and symptoms of hypersensitivity including monitoring of blood pressure and pulse during and after Feraheme administration for at least 30 minutes and until clinically stable following completion of each infusion.
*Observe for signs and symptoms of hypersensitivity during and after Injectafer administration for at least 30 minutes and until clinically stable following completion of each administration.*Monitor patients for signs and symptoms of hypersensitivity during and after Venofer administration for at least 30 minutes and until clinically

THERAPY ADMINISTRATION

☐ Ferumoxytol (Feraheme) intravenous infusion
- Dose & Frequency: ☑initial 510mg infusion followed by a second 510mg infusion 3-8 days later
- Dilution 50 - 200ml 0.9% sodium chloride or 5% dextrose solution (final concentration 2mg - 8mg per ml)
- Infuse over at least 15 minutes
- No refills ☐ Other

☐ Ferric carboxymaltose (Injectafer) intravenous infusion
- Dose & Frequency: ☐Patients > 50kg: Two 750mg doses, 7 days apart / ☐Patients < 50kg: Two 15mg/kg doses, 7 days apart
- Dilution no more than 250ml 0.9% sodium chloride
- Infuse over at least 15 minutes
- No refills ☐ Other

☐ Iron sucrose (Venofer) intravenous infusion
- Dose:
- ☐ 100mg in 100ml 0.9% sodium chloride over 30 minutes ☐ 200mg in 100ml 0.9% sodium chloride over 30minutes ☐ 300mg in 250ml 0.9% sodium chloride over 1.5 hours
- ☐ 400mg in 250ml 0.9% sodium chloride over 2.5 hours
- ☐ _____
- Frequency:

☐ Once ☐ Every 2- 3 days x _____ doses
☐ Daily x _____ doses ☐Weekly x _____ doses
☐ Monthly x _____ doses ☐Other: _____

☑ Flush with 0.9% sodium chloride at the completion of infusion
☑ Patient required to stay for 30 - min observation period
Total doses: ☐ 1 yr ☐ Other

Provider Name (Print) Provider Signature Date

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____