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

Mission Medical

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:

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
  - ☐ Dilutein 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
- ☐ Ferriccarboxymaltose (Injectafer) intravenous infusion
  - Dose & Frequency:
  - ☐ Patients > 50kg: Two 750mg doses,7 days apart
  - ☐ Patients < 50kg: Two 15mg/kg doses, 7 days apart
  - ☐ Dilute in 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 _____