

Fairfield
1817 Black Rock Turnpike
Suite 204
Fairfield, CT 06824

Greenwich
469 W Putnam Ave
Ste 205,
Greenwich, CT 06830



Provider Order Form

IRON

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS

New Referral
 Referral Renewal
 Medication/Order Change
 Benefits Verification Only
 Discontinuation Order

PHYSICIAN 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

- Ferumoxylol (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
- Ironsucrose(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

If the medication selected above is not covered or is non-preferred by the patient's insurance, the prescribing provider authorizes consideration of the clinically appropriate alternatives listed below. Final medication selection will be based on provider clinical judgment and/or payer requirements. Provider signature below confirms authorization for the above substitution(s), if applicable.

IRON IV BRANDS: Feraheme Injectafer Venofer

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____