

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

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

**E 56th & Park Midtown**  
120 East 56 Street  
Suite 300  
New York, NY 10022

**NYC**  
**E 70th St Upper East Side**  
225 E 70th Street  
Suite 1E  
New York, NY 10021



**Tarrytown**  
555 Taxter Road  
3rd Floor  
Elmsford, NY 10523

**Southampton**  
625 Hampton Road  
Southampton, NY 11968

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

**Sheepshead Bay**  
2546 East 17th Street  
Fl. 1  
Brooklyn, NY 11235

**Long Island City**  
36-36 33rd  
Suite 311  
Long Island City, NY 11106

**FIDI**  
30 Broad Street  
Suite 401  
New York, NY 10004

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

**Port Jefferson**  
12 Medical Drive  
Suite B  
Port Jefferson Station, NY 11776

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

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

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

**Massapequa**  
97 Grand Avenue  
Massapequa, NY 11758

**Gramercy**  
7 Gramercy Park West  
Lower Level  
New York, NY, 10003



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

**Holbrook**  
233 Union Avenue  
Suite 207  
Holbrook, NY 11741

**New Hyde Park**  
1991 Marcus Ave  
Suite 110  
Lake Success, NY, 11042

**Woodbury**  
7600 Jericho Tpke,  
Lower Level, Suite C500  
Woodbury NY 11797

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
- 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

**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 \_\_\_\_\_