Midnight Sun ONCOLOGY

Iron Order Form

Please include recent labs and last two office visit notes

Please fax to 907-746-7798 - Clinic Phone Number: 907-746-7771

PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: ☐M ☐F	Weight:
Patient Status: ☐ New to therapy ☐ Continuing therapy	Next due date (if applicable):

PHYSICIAN INFORMATION

Physician's Name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office phone:	Email:	
Office contact:	Office fax:	

DIAGNOSIS INFORMATION

☐ Iron Deficiency Anemia ICD10: (D50.9)	Year of Diagnosis:
☐ Other (specify):	Year of diagnosis:

INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

Primary Insurance:	ID#	Secondary Insurance:	ID#

☐ Patient has trialed/failed oral iron for 90 days ☐ Oral Iron Intolerance ☐ Hx Gastric bypass/GI Malabsorption

PRESCRIPTION INFORMATION - Iron formulation per payer guidelines (One time order)

Medication may be substituted with payer-preferred brand, generic, or biosimilar equivalent per authorization and institutional formulary

Injectafer

☐ > 50 KG: 750mg IV, 2 doses at least 7 days apart

☐ <50kg: 15mg/kg IV, 2 doses at least 7 days apart

Feraheme

☐ 510mg IV, 2 infusions 3-8 days apart

Vital signs per clinic protocol

Infusion reaction/Hydration Management per clinic

Infed: Based on weight and Hemoglobin:

☐ 1000mg ☐ 2000mg ☐3000mg

1st dose: after premeds, 50mg given IVP with 1 hr wait

Remaining 950mg over 2 hours.

Subsequent 1000mg doses over 2 hours, non-consecutive days

>1yr since previous dose, must use test dose

INFED PRE-MEDICATIONS:

☐ IV Dexamethasone: 20 mg

☐ IV Diphenhydramine: ☐ 50mg (1st dose)

☐ IV Diphenhydramine: ☐ 25mg subsequent if tolerated

☐ IV Famotidine: 20 mg

Signature (required)

PHYSICIAN SIGNATURE DATE