



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