

**IRON PRODUCTS ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_\_\_

HT: \_\_\_\_\_ in WT: \_\_\_\_\_  lbs  kg Sex:  Male  Female Allergies:  NKDA, \_\_\_\_\_

Physician Name \_\_\_\_\_ Contact Name \_\_\_\_\_ Contact Phone # \_\_\_\_\_

NPI #: \_\_\_\_\_ Tax ID#: \_\_\_\_\_ Fax #: \_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD-10 Code plus Description) \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_

**PERTINENT MEDICAL HISTORY**

Does patient have venous access?  YES  NO If yes, what type  MEDIPORT  PIV  PICC LINE  OTHER: \_\_\_\_\_

**PRESCRIPTION ORDERS**

- a) ALL MEDIPOINTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY
- b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY
- c) SUPPORTING LABWORK AND DOCUMENTATION OF ORAL IRON TREATMENT MAY BE REQUIRED BASED ON INDIVIDUAL PAYOR GUIDELINES
- d) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
<input type="checkbox"/>	VENOFER	____mg	IV		
<input type="checkbox"/>	VENOFER	200 mg	IV	ONCE EVERY WEEK	5 Doses
<input type="checkbox"/>	INJECTAFER	750 mg	IV	ONCE EVERY WEEK	2 Weeks
<input type="checkbox"/>	FERRLECIT	125 mg	IV		
<input type="checkbox"/>	FERRLECIT	250 mg	IV		
<input type="checkbox"/>	FERAHEME	510 mg	IV	ONCE, THEN REPEAT 3 – 8 DAYS LATER	2 Doses
<input type="checkbox"/>	OTHER:				

**PREMEDS**

SELECT	MEDICATION	DOSE	ROUTE
<input type="checkbox"/>	NONE	NA	NA
<input type="checkbox"/>	BENADRYL	50 mg	IV
<input type="checkbox"/>	ACETAMINOPHEN		
<input type="checkbox"/>	OXYGEN		
<input type="checkbox"/>	EPINEPHRINE	0.3mg / 0.3mL	IM
<input type="checkbox"/>	SOLU-MEDROL	125 mg	IV
<input type="checkbox"/>	Other:		

**LABS**

SELECT BELOW	LAB REQUESTED	WHEN	FREQUENCY
<input type="checkbox"/>	NONE	NA	NA
<input type="checkbox"/>	BMP	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	CMP	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	BUN/CREATININE	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	H+H:	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	Ferritin:	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	Other:	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	

NOTES: \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Time \_\_\_\_\_ Date \_\_\_\_\_

\*Signature Must Be Clear and Legible

Cosignature (If Required) \_\_\_\_\_ Time \_\_\_\_\_ Date \_\_\_\_\_

\*Signature Must Be Clear and Legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.