Fax: 832-895-4040
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adaptIV infusion

Iron (Feraheme/Injectafer/Venofer)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one):* ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one):* ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

PRE-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
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

* 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 stable following completion of the infusion.

THERAPY ADMINISTRATION

☐ **Ferumoxytol** (Feraheme) intravenous infusion
- Dose & Frequency: ☐ initial 510mg infusion followed by a second 510mg infusion 3-8 days later
- Dilute in 50 - 200ml 0.9% sodium chloride or 5% dextrose solution (final concentration 2mg - 8mg per ml)
- Infuse over at least 15 minutes
- No refills

☐ **Ferric carboxymaltose** (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

☐ **Iron sucrose** (Venofer) intravenous infusion

Dose (choose one):

	Dose	Add to	Rates	Length
☐	100 mg	100ml NS	200 ml/hr	30 minutes
☐	200 mg	200ml NS	200 ml/hr	60 minutes
☐	300 mg	250 ml NS	166.6 ml/hr	90 minutes
☐	400 mg	250 ml NS	100 ml/hr	2.5 hours
☐	500 mg	250 ml NS	62.5 ml/hr	4 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 infusion completion
☐ Patient required to stay for 30-min observation period

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

_____ _____ _____
Provider Name (Print) *Provider Signature* *Date*

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK