IV Iron Therapies

Provider Order Form Rev. 07/2023

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Iron deficiency anemia, unspecified, D50.9

☐ _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Feraheme® (ferumoxytol)	510 mg	☐ Two-dose regimen: Infuse IV over 30 minutes once, followed by a second IV dose over 30 minutes 3-8 days later *Administer while patient is in reclined or semi-reclined position. *Observe patient for 30 minutes after completion of infusion.
INFed® (iron dextran)	☐ 100 mg ☐ _____ mg *Maximum dose = 1000 mg*	☐ **TEST Dose**: 25 mg IV over 30 seconds x 1 dose. *Observe patient for 1 hour before administering the remainder of therapeutic dose. ☐ Infuse 100mg IV over 60 minutes every _____ day for a total of _____ doses ☐ Infuse IV over _____ hours (range 4-6 hours) x 1 dose
Injectafer® (ferric carboxymaltose)	**TWO-dose regimen** ☐ ≥50kg: 750 mg ☐ <50kg: _____mg (15 mg/kg) **ONE-dose regimen** ☐ ≥50kg: _____mg (15 mg/kg) *Maximum dose = 1000 mg*	☐ TWO-dose regimen: Infuse IV over 15-30 minutes once, followed by a second IV dose over 15-30 minutes 7 days later ☐ ONE-dose regimen: Infuse IV over 15-30 minutes x 1 dose
Monoferric® (ferric derisomaltose)	☐ ≥50kg: 1000 mg ☐ <50kg: _____mg (20 mg/kg)	☐ Infuse IV over 15-30 minutes x 1 dose
Venofer® (iron sucrose)	☐ 100 mg ☐ 200 mg	☐ Infuse 100mg IV over 30 minutes 3 times weekly x _____ doses ☐ Infuse 200mg IV over 30 minutes 3 times weekly x _____ doses
OTHER:		

Is patient currently receiving therapy above from another facility? ☐ **NO** ☐ **YES**

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

PRE-MEDICATION ORDERS:

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO

☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV

☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

☐ Iron deficiency anemia is confirmed by labwork.

☐ The patient requires intravenous iron therapy for iron supplementation. ***Please select all that apply:***

- ☐ Inadequate response to prior oral therapy
- ☐ Intolerance to prior oral therapy
- ☐ Contraindication to oral therapy (e.g., inflammatory bowel disease)
- ☐ Decreased absorption of oral iron (e.g., following gastric bypass surgery)
- ☐ Iron (blood) loss at rate too rapid for oral intake to compensate for loss
- ☐ Other: _____

LAB AND TEST RESULTS (required)

☐ CBC ☐ Serum Iron ☐ Serum Ferritin ☐ Other: _____

PRIOR FAILED THERAPIES (oral/IV iron supplementation)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____