IV Iron (Feraheme®, Venofer®)

Provider Order Form Rev. 07/2023.v2

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

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

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.
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 Iron:		

An alternative intravenous iron product may be ordered and administered by Healix Infusion Care providers based on insurance policy requirements, reimbursement, and/or other factors. **NOTE: Patients with Aetna, Cigna, Humana or UHC insurance must try and fail Venofer first.**

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: _____

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