Health Care Medical
Infusion Specialties
An Access Infusion Care Company

IV IRON ORDERS

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ Completed and Signed Referral
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

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Print, complete, and fax completed form to (769) 233-8051

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PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Height: Weight: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change

First dose? ☐ Yes ☐ No - Date of last infusion:	Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS

☐ Dx Code/description:	☐ Secondary Dx Code/description(required):

REQUIRED DOCUMENTATION

☐ This signed order ☐ Patient demographics and insurance information ☐ H&P, labs, tests, progress notes supporting diagnosis

☐ CBC and Iron Panel results (within 30 days)	☐ Phosphorus level (Injectafer)

- Prior Therapies (include documentation of failed oral iron or iron intolerance):

PRESCRIBING INFORMATION

LAB ORDERS

Frequency: Every Labs: ☐ CMP ☐ CBCwdif ☐ Serum Phosphorus ☐ Other:

PREMEDICATIONS (administer 30 minutes prior to infusion)

Acetaminophen: ☐ 650mgPO ☐ 1000mgPO

MEDICATION

Medication	Strength	Dose/Directions	Quantity
☐ **Iron Sucrose (Venofer)**	100mg/5ml	☐ Infuse 200mg in 0.9%NS 100mL IV over 30 minutes every 2 days x 5 doses ☐ Infuse 200mg in 0.9%NS 100mL IV over 30 minutes every 7 days x 5 doses ☐ Infuse 300mg in 0.9%NS 250mL IV over 90 minutes every 3 days x 3 doses ☐ Infuse 500mg in 0.9&NS 250mL IV over 3.5 hours every 7 days x 2 doses	☐ 5 doses/10 vials ☐ 5 doses/10 vials ☐ 3 doses/9 vials ☐ 2 doses/5 vials
☐ **Ferric Carboxymaltose (Injectafer)**	750mg/15ml	☐ Infuse 750mg in 0.9%NS 250mL IV over 30 minutes every 7 days x 2 doses ☐ If <50kg, infuse 15mg/kg, (max dose 750mg) in 0.9%NS 250mL IV over 30 minutes every 7 days x 2 doses	☐ 2 doses/2 vials ☐ 2 doses/2 vials

If not specified, order will be valid for 1 year from the date of signature.

OBSERVATION

Observe the patient for at least 30 minutes after the infusion.

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

Prescriber Signature X: _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

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