IRON

○ New Prescription/Referral
○ Prescription Refill

# of Refills:

Rx: **Patient Name:** **DOB:**

☐ **INJECTAFER** ◉ 1st Choice

1st Dose: 750mg IV infusion in no more than 250ml of 0.9% NaCl over at least 15 mins

2nd Dose: 7 days after the 1st dose, 750mg IV infusion in no more than 250ml of 0.9% NaCl over at least 15 mins or slow IV push over 7.5 mins

☐ **VENOFER** ○ 1st Choice

200mg in 100ml NaCl over 15 mins x 5 doses via IV infusion over a 14-day period. Total = 1000mg.

200mg IV push over 2 to 5 mins x 5 doses over a 14-day period. Total = 1000mg.

☐ **FERRLECIT**

125mg in 100ml NaCl over 1hr via IV infusion 48-72 hrs apart x8 doses.

☐ **INFED**

1000mg in 250ml NS IV x1 dose

OTHER ORDERS:

Dx: ☐ **Iron Deficiency Anemia (D50.9)** ☐ **Patient has intolerance to oral iron or unsatisfactory response to oral iron.**

Others:

Pre-Medication:

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP

☐ Tylenol _____mg PO
○ 650mg ○ 975mg ○1000mg

☐ Benadryl _____mg
○ 25mg ○ IV
○ 50mg ○ PO

ANA Kit Protocol:
☐ OK to use

Other PreMeds:

Physician Signature	NPI	Date: (Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION:

Physician Name: **CLINIC:**

Contact Information:

Phone: **Fax:** **Email:**

Other:

Office Mailing Address:

Check that the following are included:

☐ **Patient demographics & Insurance attached**
☐ **Clinical progress notes**
☐ **Lab Results**
☐ **History and Physical**
☐ **Diagnosis (supporting)**
☐ **Medication List**