# IRON

- New Prescription/Referral
- Prescription Refill

**# of Refills:**

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

## VENOFER

- 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.

## INJECTAFER

- 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

- **OTHER ORDERS**:

**Dx:** Iron Deficiency Anemia (D50.9)

**Others:**

- **Patient has intolerance to oral iron or unsatisfactory response to oral iron.**

**Pre-Medication:**

- Solumedrol 125mg IVP
- Solu-Cortef 100mg IVP
- Tylenol ___________mg PO
  - 650mg
  - 975mg
- Benadryl ______mg
  - 25mg
  - 50mg
  - IV
  - PO

**ANA Kit Protocol:**

- OK to use

**Other PreMeds:**

NPI#:

Physician Signature

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:** | **Other:** | **Email:**

**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