

IRON

New Prescription/Referral
Prescription Refill

Of Refills:

Rx:

Patient Name:

Patient Weight:

kg

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:

May substitute with any formulary-approved intravenous iron preparation per insurance coverage

Pre-Medication:

Solumedrol 125mg IVP

Tylenol _____ mg PO

Benadryl _____ mg PO

Solu-Cortef 100mg IVP

650 mg 975 mg 1000mg

25 mg IV
50 mg PO

Others: _____

ANA Kit Protocol:

OK to use

Dx:

Iron Deficiency Anemia (ICD-10: D50.9)

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

Other: _____

ICD-10: _____

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:

Phone:

Fax:

Email:

Other:

Office Mailing Address:

Please include the following

Patient demographics
Lab Results

Insurance attached
Clinical progress notes

Diagnosis(supporting)
Medication list

History & Physical
Other Test Results