

Ferinject Order Form (Pediatric)

Patient information			
Name:	DOB:	ULI:	Allergies:
Address:	Phone Number:	E-mail address:	Weight (kg):

Clinical Information		
Hgb:	Ferritin:	Date of Lab work:
Diagnosis:		Relevant Medical History/ Notes:

Prescriber Information		
Name:	Phone Number:	Fax number:

Has patient trialed oral iron supplementation? YES NO

Has patient previously received IV iron and if so was there a reaction? YES NO Comments: _____

Ferinject (ferric carboxymaltose) IV in Pediatrics ages 8-17 years (select one)				
HGB (g/L)	Body weight 30kg	Body weight 40kg	Body weight 50kg	Body Weight 60kg
70	<input type="checkbox"/> 900mg	<input type="checkbox"/> 1200mg	<input type="checkbox"/> 1350mg	<input type="checkbox"/> 1500mg
90	<input type="checkbox"/> 750mg	<input type="checkbox"/> 1100mg	<input type="checkbox"/> 1200mg	<input type="checkbox"/> 1350mg
110	<input type="checkbox"/> 600mg	<input type="checkbox"/> 900mg	<input type="checkbox"/> 1000mg	<input type="checkbox"/> 1100mg
130	<input type="checkbox"/> 450mg	<input type="checkbox"/> 700mg	<input type="checkbox"/> 750mg	<input type="checkbox"/> 800mg
Greater than 150	<input type="checkbox"/> 300mg	<input type="checkbox"/> 500mg	<input type="checkbox"/> 500mg	<input type="checkbox"/> 500mg

Prescription Frequency (select one)	
<i>Administer Ferinject as follows:</i> <ul style="list-style-type: none"> Maximum single dose: 15mg/kg body weight or 750mg in pediatrics If the total iron needed is greater than 750mg, additional doses should be administered at a minimum of 7 days apart from initial dose Maximum Pregnancy dosing (in 16 weeks +): 1000mg (Hgb greater than 90) or 1500mg (Hgb 90 or less) 	
<input type="checkbox"/> Administer total single dose	<input type="checkbox"/> Split dosing required Day 0: _____mg Day __: _____mg Day __: _____mg
Previous history of reaction to any iron products, to give the following prior to infusion: <ul style="list-style-type: none"> Methylprednisolone 50-125mg IV Diphenhydramine 25-50mg PO/IV Acetaminophen 325-650mg PO Other: _____ 	For any adverse reaction DURING infusion to give the following: <ul style="list-style-type: none"> Hydrocortisone 50-100mg IV PRN x1 Diphenhydramine 25-50mg PO/IV PRN Acetaminophen 325-650mg PO PRN Dimenhydrinate 25-50mg PO/IV PRN

Prescriber Signature:

Date:

Please fax completed form and fax to Renew Infusions at 1-833-930-2673

Please advise patients they will receive a call from our nursing staff within 7 days. Infusion fee of \$225 (as of March 1st, 2026) will apply for infusions administered at Renew Infusions. Patient will be provided a receipt to be used for their Health Spending account (if applicable) or for income tax purposes. Prescriber will be notified if Renew Infusion staff is unable to contact patient or if patient declines infusion. A post infusion report will be faxed to prescriber once infusion is completed.