IRON INFUSION ORDER FORM
P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Allergies: _____

Primary ICD-10: _____

- ☐ Iron Deficiency Anemia
- ☐ Iron Deficiency Unspecified
- ☐ Iron Deficiency Anemia secondary to Inadequate Dietary Iron Intake
- ☐ Other medical necessity: _____

Secondary ICD-10: _____

- ☐ Adverse effect of other drug (oral iron intolerance or not adequate)
- ☐ End-Stage Renal Disease
- ☐ Intestinal Malabsorption
- ☐ Chronic Kidney Disease
- ☐ Other medical necessity: _____

INFED THERAPY ORDER

- ☐ **Infed 1000 mg IV** x 1 dose
- ☐ **Infed _____mg IV** x 1 dose
- ☐ **Infed _____ mg/kg IV** x 1 dose

*** Administer 25 mg test dose over at least 30 seconds, wait 1 hour before administering the remaining dose***

INJECTAFER THERAPY ORDER

☐ **Patient weighing less than 50kg (110 lbs.)**
Dose: Injectafer 15mg/kg IV
Frequency: Give 2 doses at least 7 days apart
Not to exceed 1500mg

☐ **Patient weighing 50kg (110 lbs.) or greater**
Dose: Injectafer 750mg IV
Frequency: Give 2 doses at least 7 days apart not to exceed 1500 mg

MONOFERRIC THERAPY ORDER

☐ **Patient weighing less than 50kg (110 lbs.)**
Dose: Monoferric 20mg/kg IV x 1 dose

☐ **Patient weighing 50kg (110 lbs.) or greater**
Dose: Monoferric 1000mg IV x 1 dose

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30 kg (>66lbs.): 0.3mg IM or subQ; may repeat in 5-10 minutes x 1
  - 15-30 kg (33-66lbs.) 0.15mg IM or subQ; may repeat in 5-10 minutes x 1
- Solu-Medrol 125mg IV as needed
- NS 250-500mL IV bolus as needed

Flush Orders: NS 1-20mL pre/post infusion PRN

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

ACTIVE infusions

COMPREHENSIVE SUPPORT FOR IRON INFUSION THERAPY

P: 240-200-4464 F: 240-892-3005

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete previous page)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's mediation list
- ☐ Supporting clinical notes (H&P) to support primary diagnosis
  - ☐ Does the patient have an intolerance, contraindication, or documented tried and failed use of oral iron?
    - ☐ Yes ☐ No
    - If yes, which drug(s)? _____
  - ☐ Does the patient have an intolerance or documented tried and failed use of an IV iron product?
    - ☐ Yes ☐ No
    - If yes, which drug(s)? _____
- ☐ Labs showing iron deficiency anemia attached
- ☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

- ☐ **Labs indicating iron deficiency anemia – please attach**

Please fax all information to 240-892-3005 or email to info@activeinfusions.com for assistance