SPECIALTY INFUSION CENTER
An Access Infusion Care Company

IV IRON ORDERS

CENTERS AT SIC
An Access Infusion Care Managed Company

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ Completed and Signed Referral
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

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Print, complete, and fax completed form to (855) 857-3834

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PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Height: Weight: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change	
First dose? ☐ Yes ☐ No - Date of last infusion:	Line type: ☐PIV ☐PICC ☐Port ☐Other

DIAGNOSIS
☐ Dx Code/description:
☐Secondary Dx Code/description(required):

REQUIRED DOCUMENTATION ☐ Signed order ☐ Demographics and insurance info ☐ H&P, labs, tests, progress notes supporting dx	
☐CBC and Iron Panel results (within 30 days)	☐Phosphorus level (Injectafer)
• Prior Therapies (include documentation of failed oral iron or iron intolerance):	

PRESCRIBING INFORMATION

LAB ORDERS

Frequency: Every Labs: ☐CMP ☐CBCwdif ☐Serum Phosphorus

PREMEDICATIONS (administer 30 minutes prior to infusion)

Acetaminophen: ☐650mgPO ☐1000mgPO

MEDICATION

Medication	Strength	Dose/Directions	Quantity
☐**Iron Sucrose (Venofer)**	100mg/5ml	☐Infuse 200mg in 0.9%NS 100mL IV over 30 minutes every 2 days x 5 doses ☐Infuse 200mg in 0.9%NS 100mL IV over 30 minutes every 7 days x 5 doses ☐Infuse 300mg in 0.9%NS 250mL IV over 90 minutes every 3 days x 3 doses ☐Infuse 500mg in 0.9&NS 250mL IV over 3.5 hours every 7 days x 2 doses	☐5 doses/10 vials ☐5 doses/10 vials ☐3 doses/9 vials ☐2 doses/5 vials
☐**Ferumoxytol (Fereheme)**	510mg/17ml	☐Infuse 510mg(17mL) in 0.9%NS 100mL IV over 30 minutes x 1 dose ☐Infuse 510mg(17mL) in 0.9%NS 100mL IV over 30 minutes every 7 days x 2 doses	☐1 dose/1 vial ☐2 doses/2 vials
☐**Ferric Carboxymaltose (Injectafer)**	750mg/15ml	☐Infuse 750mg in 0.9%NS 250mL IV over 30 minutes every 7 days x 2 doses ☐ If <50kg, infuse 15mg/kg, (max dose 750mg) in 0.9%NS 250mL IV over 30 minutes every 7 days x 2 doses	☐2 doses/2 vials ☐2 doses/2 vials

If not specified, order will be valid for 1 year from the date of signature.

OBSERVATION

Observe the patient for at least 30 minutes after the infusion.

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

Prescriber Signature X: _____ **Date:** _____

☐**Product Substitution Permitted** ☐**Dispense as Written**

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