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# Iron (Feraheme, Injectafer, Monoferric, Venofer)

Provider Order Form rev. 5/20/2022

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Phone: \_\_\_\_\_ Patient Email: \_\_\_\_\_

NKDA Allergies: \_\_\_\_\_ Weight lbs/kg: \_\_\_\_\_ Height: \_\_\_\_\_

**Patient Status:**    New to Therapy    Continuing Therapy    Therapy Change    Next Due Date (if applicable): \_\_\_\_\_

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## DOCUMENTATION (REQUIRED)

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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### ICD-10 CODE

D64.9 Anemia unspecified (includes Anemia due to medications)

D63.1 Anemia in chronic kidney disease (select secondary code to indicate type of CKD)

    N18.30 CKD, stage 3 unspecified

    N18.4 CKD, stage 4

    N18.5 CKD, stage 5

    N18.6 End stage renal disease

Other: \_\_\_\_\_

### MEDICATION ORDER

**Feraheme (ferumoxylol)**  
Dose: 510mg IV  
Frequency: \_\_\_\_\_  
One dose followed by a second dose 3 to 8 days later  
Other: \_\_\_\_\_

**Injectafer (ferric carboxymaltose)**  
Dose: 15mg/kg IV    750mg IV    Other: \_\_\_\_\_  
Frequency: \_\_\_\_\_  
Give twice, first and second dose are separated by at least 7 days  
Give twice. First dose is on day 0 and second dose is on day \_\_\_\_\_  
Other: \_\_\_\_\_

### PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg 650mg 1000mg PO

diphenhydramine (Benadryl) 25mg 50mg / PO IV

methylprednisolone (Solu-Medrol) 40mgIV 125mg IV

Other: \_\_\_\_\_

**Monoferric (ferric derisomaltose)**  
Dose: 1,000mg IV    20mg/kg IV    Other: \_\_\_\_\_  
Frequency: Once    Other: \_\_\_\_\_

**Venofer (iron sucrose)**  
Dose: 100mg IV    200mg IV    300mg IV  
          400mg IV    0.5mg/kg  
Frequency: Once    Other: \_\_\_\_\_  
Route: Slow IV Push    Infusion

### SPECIAL INSTRUCTIONS

Order Expiration Date (mm/dd/yy): \_\_\_\_\_  
(If not indicated order will expire one year from date signature)

Provider Name (Print) \_\_\_\_\_ Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Check here if this is a stat order