Injectafer

Orders

FERRIC CARBOXYMALTOSE

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Locations: ☐ Dublin, OH ☐ Lancaster, OH

INFUSE ONE OHIO

PATIENT INFORMATION

Patient Name _____ **Date of Birth** _____ **Gender** ☐ M ☐ F

Patient Address / City / State / ZIP _____ **Phone** _____

DIAGNOSIS

PLEASE PROVIDE ICD-10 CODE

☐ Iron Deficiency Anemia _____ ☐ Iron Deficiency with Heart Failure _____

☐ Other _____

PRE-MEDICATIONS

OPTIONAL - CHECK ALL THAT APPLY

☐ Acetaminophen 1000 mg PO
☐ Diphenhydramine 25 mg PO
☐ Cetirizine 10 mg PO
☐ Other _____

☐ Solu-Medrol 125 mg IVP
☐ Solu-Cortef 100 mg IVP
☐ Diphenhydramine 25 mg IVP
☐ Other _____

INJECTAFER ORDERS

DOSAGE & FREQUENCY

PATIENT WEIGHT

Pounds _____ **Kilograms** _____

Iron deficiency anemia

☐ >50 kg: Two 750 mg doses, 7 days apart
☐ <50 kg: Two 15 mg/kg doses, 7 days apart

Iron deficiency with heart failure

<70 kg

☐ Hb <10 g/dL: 1000 mg day 1 and 500 mg week 6
☐ Hb 10-14 g/dL: 1000 mg once
☐ Hb >14 g/dL: 500 mg once

>70 kg

☐ Hb <10 g/dL: 1000 mg day 1 and 1000 mg week 6
☐ Hb 10-14 g/dL: 1000 mg day 1 and 500 mg week 6
☐ Hb >14 g/dL: 500 mg once

Please fax the patient's ferritin or TSAT results with this completed form.

ORDERING PROVIDER

Provider NPI _____ **Phone** _____ **Fax** _____

Provider Name _____

Provider Address _____

Prescriber Signature _____ **Date** _____