Fax: 614-929-7199 | Phone: 614-929-3349| Email: info@infuseoneohio.com

(Ferric carboxymaltose)

Injectafer infusion orders

INFUSE ONE OHIO

Patient Name _____ DOB _____

Phone Number _____ M ____ F _____

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Iron Deficiency with Heart Failure

☐ _____ Iron Deficiency Anemia

☐ _____ Other

PRE-MEDICATIONS (optional)

- ☐ Acetaminophen 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____ (other)
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ (other)

Injectafer (ferric carboxymaltose) ORDERS

DOSAGE & FREQUENCY

Iron deficiency anemia:

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

Patient Weight

_____ **lbs**

_____ **kg**

Iron deficiency with heart failure:

<70kg

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

>70kg

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

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

ORDERING PROVIDER

Provider NPI: _____Phone_____ Fax_____

Provider Name _____

Provider Address _____

Signature _____ Date_____