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

(Ferumoxytol)

Feraheme infusion orders

Patient Name _____ DOB _____

Phone Number _____ M ____ F _____

DIAGNOSIS *Please provide ICD-10 code*

☐ _____Iron Deficiency Anemia ☐ _____ Other

PRE-MEDICATIONS

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

Feraheme (ferumoxytol) ORDERS

DOSAGE & FREQUENCY

☐ 510mg infusion followed by a second 510mg infusion _____ days later

☐ Other: _____

Patient Weight

_____ **lbs**

_____ **kg**

NOTES:

ORDERING PROVIDER

Provider NPI: _____Phone_____ Fax_____

Provider Name _____

Provider Address _____

Signature _____ Date_____