Provider Order Form

IRONS (FERAHEME, VENOFER, INJECTAFER)

Uptiv Health

PATIENT

Full Name: ______________________________ DOB: ______________

Mobile Phone: ______________________________ Weight: ______ ☐ lbs ☐ kg

Allergies: ______________________________ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: ________ Next Treatment Date: _______

DIAGNOSIS ICD-10 code (must be specified)

☐ Iron Deficiency Anemia D50. ______________
☐ Chronic kidney disease N18. ______________
☐ Other ______________________________
☐ Anemia in CKD D63.1
☐ Anemia in Chronic Disease D63.8

PROVIDER

Provider Name: ______________________________ Provider NPI: ______________________________

Practice Name: ______________________________ Referral Coordinator Name: ______________________________

Practice Address: ______________________________

Phone: ______________ Fax: ______________ Email: ______________________________

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg
☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg
☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg
☐ Cetrizine (Zyrtec) 10 mg PO
☐ Other: ______________________________

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☐ Feraheme (Ferumoxytol), IV	☐ 510 mg	☐ 510 mg, followed by 510 mg 3 to 8 days later
☐ Injectafer (Ferric Carboxmaltose), IV	☐ 750 mg ☐ 15 mg/kg	☐ Two 750mg doses, 7 days apart ☐ Two 15mg/kg doses, 7 days apart
☐ Venofer (Iron sucrose)	☐ 100 mg ☐ 200 mg ☐ 300 mg ☐ 400 mg	☐ Once ☐ Every 2-3 days x _____ doses ☐ Daily x _____ doses ☐ Weekly x _____ doses ☐ Monthly x _____ doses

Other: ______________________________

No Refills.
☒ Flush with 0.9% sodium chloride at infusion completion.
☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX

______________________________ ______________________________
Provider Signature Date