IRON

☐ New Prescription/Referral
☐ Prescription Refill

# of Refills:

Rx:

Patient Name:

DOB:

VENOFER

☐ 200mg in 100ml NaCl over 15 mins x 5 doses via IV infusion over a 14-day period. Total = 1000mg.
☐ 200mg IV push over 2 to 5 mins x 5 doses over a 14-day period. Total = 1000mg.

INJECTAFER

☐ 1st Dose: 750mg IV infusion in no more than 250ml of 0.9% NaCl over at least 15 mins
☐ 2nd Dose: 7 days after the 1st dose, 750mg IV infusion in no more than 250ml of 0.9% NaCl over at least 15 mins or slow IV push over 7.5 mins

☐ **OTHER ORDERS**:

Dx:
☐ **Iron Deficiency Anemia (D50.9)**
☐ **Patient has intolerance to oral iron or unsatisfactory response to oral iron.**

Others:

Pre-Medication:

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP

☐ Tylenol _____mg PO
☐ 650mg ☐ 975mg

☐ Benadryl _____mg
☐ 25mg ☐ IV
☐ 50mg ☐ PO

ANA Kit Protocol:
☐ OK to use

Other PreMeds:

NPI#:

Physician Signature

Date: (Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION:

Physician Name:

CLINIC:

Contact Information:

Phone:

Fax:

Other:

Email:

Office Mailing Address:

Check that the following are included:

☐ **Patient demographics & Insurance attached**
☐ **Clinical progress notes**
☐ **Lab Results**
☐ **History and Physical**
☐ **Diagnosis (supporting)**
☐ **Medication List**