

FERAHEME ORDER FORM

Date: _____ Patient Name: _____ Date of Birth: _____ Allergies: _____ Weight: _____ lbs OR _____ kg	ICD-10 Code: <input type="checkbox"/> D50.0 Iron deficiency anemia secondary to blood loss (chronic) <input type="checkbox"/> D50.8 Other iron deficiency anemia <input type="checkbox"/> D50.9 Iron deficiency anemia, unspecified <input type="checkbox"/> D63.1 Anemia in chronic kidney disease (Code CKD Stage First) <input type="checkbox"/> D63.8 Anemia in other chronic disease (Code underlying disease first) <input type="checkbox"/> Other: _____
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Therapy Status Please check any of the following that apply: <input type="checkbox"/> Patient has previously failed oral iron therapy. <input type="checkbox"/> Patient has previously been treated with Feraheme or other IV iron. <input type="checkbox"/> Patient has previously experienced an adverse reaction from an iron therapy. <input type="checkbox"/> Patient has chronic renal disease.	Provider Information Ordering Provider: _____ Provider NPI: _____ Provider Phone: _____ Provider Fax: _____ Provider Address: _____
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MEDICATION ORDER

Feraheme	<input type="checkbox"/> Feraheme 510mg IV x two total doses, separated by 3-8 days.	<i>✓ Patient will be observed for signs and symptoms of hypersensitivity during infusion and for at least 30 minutes post infusion.</i>	Please include the following lab results required for infusion: <i>✓ Hemoglobin and Hematocrit within past 60 days</i> <i>✓ Iron Studies within past 60 days</i>
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PRE-MEDICATIONS

^{Oral} <input type="checkbox"/> Acetaminophen: __ 325mg __ 500mg __ 650mg <input type="checkbox"/> Loratadine: 10 mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: __ 25mg __ 50mg <input type="checkbox"/> Famotidine: __ 20mg __ 40mg <input type="checkbox"/> Ibuprofen: __ 200mg __ 400mg __ 600mg <input type="checkbox"/> Ondansetron: __ 4mg __ 8mg <input type="checkbox"/> Other _____	^{IV} <input type="checkbox"/> Dexamethasone: __ 4mg __ 8mg <input type="checkbox"/> Diphenhydramine: __ 25mg __ 50mg <input type="checkbox"/> Famotidine: __ 20mg __ 40mg <input type="checkbox"/> Methylprednisolone 125mg <input type="checkbox"/> Hydrocortisone 100mg <input type="checkbox"/> Ondansetron: __ 4mg __ 8mg <input type="checkbox"/> Other _____
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LAB ORDERS (Please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

Surveillance lab ordering, and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 800-223-4063) <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
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By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Dispense as Written: _____ Prescriber Name Date	Substitution Allowed: _____ Prescriber Name Date
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