

FERRLECIT ORDER FORM

Date:
Patient Name:
Date of Birth:
Allergies:
Weight: lbs OR kg

ICD-10 Code:
D50.0 Iron deficiency anemia secondary to blood loss (chronic)
D50.8 Other iron deficiency anemia
D50.9 Iron deficiency anemia, unspecified
D63.1 Anemia in chronic kidney disease (Code CKD Stage First)
D63.8 Anemia in other chronic disease (Code underlying disease first)
Other:

Therapy Status
Please check any of the following that apply:
Patient has previously failed oral iron therapy.
Patient has previously been treated with Ferrlecit or other IV iron.
Patient has previously experienced an adverse reaction from an iron therapy.
Patient has chronic renal disease.

Provider Information
Ordering Provider:
Provider NPI:
Provider Phone:
Provider Fax:
Provider Address:

MEDICATION ORDER

Ferrlecit
Patient will be observed for signs and symptoms of hypersensitivity during infusion and for at least 30 minutes post infusion.
Please include the following lab results required for infusion:
Hemoglobin and Hematocrit within past 60 days
Iron Studies within past 60 days

PRE-MEDICATIONS

Acetaminophen: Oral 325mg 500mg 650mg
Loratadine: 10 mg
Cetirizine: 10mg
Diphenhydramine: 25mg 50mg
Famotidine: 20mg 40mg
Ibuprofen: 200mg 400mg 600mg
Ondansetron: 4mg 8mg
Other
Dexamethasone: IV 4mg 8mg
Diphenhydramine: 25mg 50mg
Famotidine: 20mg 40mg
Methylprednisolone 125mg
Hydrocortisone 100mg
Ondansetron: 4mg 8mg
Other

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**
History & Physical, Last Office Visit Note
Patient Demographics and Insurance Information
Medication List
Recent Lab Work

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