

**VENOFER ORDER FORM**

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

**MEDICATION ORDER**

<p><input type="checkbox"/> Venofer _____ mg to be administered IV per protocol weekly for a total of _____ doses.</p> <p><input type="checkbox"/> Venofer _____ mg to be administered IV per protocol every _____ weeks for a total of _____ doses.</p> <p style="text-align: center;">**Max dosing of 1,000mg per course*</p>	<p><i>✓ Patient will be observed for signs and symptoms of hypersensitivity during infusion and for at least 30 minutes post infusion.</i></p>	<p><b>Please include the following lab results required for infusion:</b></p> <p><i>✓ Hemoglobin and Hematocrit within past 60 days</i></p> <p><i>✓ Iron Studies within past 60 days</i></p>
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**PRE-MEDICATIONS**

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

**OTHER REQUIRED DOCUMENTATION**

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

<p>Dispense as Written: _____</p> <p>_____ Prescriber Name</p> <p>_____ Date</p>	<p>Substitution Allowed: _____</p> <p>_____ Prescriber Name</p> <p>_____ Date</p>
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