TwelveStone Health Partners

Fax Referral To:

(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

VENOFER 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 Venofer 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

☐ Venofer

- ☐ Venofer _____mg to be administered IV per protocol weekly for a total of _____ doses.
- ☐ Venofer _____mg to be administered IV per protocol every _____weeks for a total of _____ doses.

**Max dosing of 1,000mg per course*

✓ *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

Oral

- ☐ Acetaminophen: ___325mg ___500mg __650mg
- ☐ Loratadine: 10 mg
- ☐ Cetirizine: 10mg
- ☐ Diphenhydramine: ___25mg ___50mg
- ☐ Famotidine: ___20mg ___40mg
- ☐ Ibuprofen: ___200mg ___400mg ___600mg
- ☐ Ondansetron: ___4mg ___8mg
- ☐ Other_____

IV

- ☐ Dexamethasone: ___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)

Surveillance lab ordering, and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- 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

V 6.30.22