

**Richmond**  
7110 Forest Ave, Suite 203  
Richmond, VA 23226



**Prince George**  
2025B Waterside Rd  
Prince George, VA 23875

**Physician Order - Feraheme (ferumoxytol)**

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose/Frequency Change <input type="checkbox"/> Order Renewal

Location Preference (optional)
<input type="checkbox"/> Richmond <input type="checkbox"/> Prince George

\* \* If the patient has a central line - we need official placement report, diagnostic imaging to confirm tip placement and date of last access \* \*

DIAGNOSIS AND ICD 1-0 CODE	
<input type="checkbox"/> Iron Deficiency Anemia	D50.9
<input type="checkbox"/> Iron Deficiency Anemia due to blood loss	D50.0
<input type="checkbox"/> Other: _____	ICD10 _____

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress Notes
<input type="checkbox"/> Patient Demographics AND Insurance Information	<input type="checkbox"/> Labs and Tests Supporting Primary Dx
<input type="checkbox"/> CBC results, within 14 days	<input type="checkbox"/> Ferritin OR Iron Saturation results, within 14 days
Is your patient unable to tolerate, or had inadequate response to oral iron supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No	

MEDICATION ORDERS**	
Dosing	<input type="checkbox"/> Feraheme 510mg infuse IV over 30 minutes once, followed by a second IV dose over 30 minutes 3-8 days later
Patient Weight = _____ kg	Patient Height = ____ ft ____ in

\*\*Patient weight is required for all weight based therapies - please indicate weight in kilograms.

PREMEDICATIONS
<input type="checkbox"/> Acetaminophen 650mg PO prior to Feraheme infusion
<input type="checkbox"/> Diphenhydramine 25mg PO prior to Feraheme infusion
<input type="checkbox"/> Methylprednisolone 40mg slow IVP
<input type="checkbox"/> Other:

Please note: if an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing.

PRESCRIBER INFORMATION			
Prescriber Name:	NPI:	Contact:	
Phone:	Fax:	Email:	
Prescriber Signature:		Date:	

**Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com**

Fax completed form and ALL documentation to 804-554-5848

All information contained in this form is strictly confidential and will become part of the patient's record.