

INJECTAFER® (ferric carboxymaltose)

Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
 DOB: _____ Allergies: NKDA _____
 Phone Number: _____
 Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

Required Documentation

- Patient Demographics and Insurance Card Medication List
 Clinical/Progress Notes Supporting Dx Recent labs indicating iron deficiency anemia (Iron studies and CBC)

Primary Diagnosis

 ICD-10 Code (required): _____

- Iron Deficiency Anemia Other: _____

Pre-Medication

- Acetaminophen (Tylenol) PO 500mg 650mg 1000mg
 Diphenhydramine (Benadryl) 25mg 50mg PO IV
 Methylprednisolone (Solu-Medrol) IV 40mg 125mg
 Cetirizine (Zyrtec) 10 mg PO
 Other: _____

Therapy Administration

- Injectafer 750mg IV weekly for 2 doses
 Injectafer 15mg/kg IV weekly for 2 doses
 Other: _____

Refills:

- No Refills Other: _____

 **Patients will be monitored for 30 minutes following infusion unless otherwise specified. Max dose is 1,500mg for a single dose.**

- RN to flush and lock VAD/CVAD per violet health protocol (see violetinfusions.com/protocol for policy)
 Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy)
 RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines.
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration.
 Other: Please fax alternative reaction orders, flush orders, or nursing administration orders if checking this box

Provider Information

Provider Name: _____ Office Contact Person: _____
 Referring Practice Name: _____ Phone Number: _____
 Referring Practice Address: _____ Fax Number: _____
 City, State, Zip: _____ Email: _____
 Provider NPI: _____
 Provider Signature: _____ Date: _____