

# FERAHEME® (ferumoxytol)

## 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

Per violet health protocol: No standard recommended pre-medications for Feraheme   Other: \_\_\_\_\_

## Therapy Administration

### Medication Order:

Initial dose of Feraheme 510 mg IV followed by a second dose of Feraheme 510mg IV 3-8 days later

Other: \_\_\_\_\_

### Refills:

x 1 year  Other: \_\_\_\_\_

 Order valid for one year unless otherwise stated

## Nursing Orders

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

## Lab Orders

### Labs to be drawn:

- CBC  
 Ferritin, serum  
 Iron Panel  
 Other: \_\_\_\_\_

### Timing of Lab Draws:

- Pre- Treatment  
 1 week after therapy completion  
 \_\_\_\_\_ weeks after therapy completion

## 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: \_\_\_\_\_