Venofer (iron sucrose) Order Form (Chronic Kidney Disease)

Oregon Specialty Infusion
A Practice of Oregon Specialty Group

Demographics

Patient Name: _____ Ordering Provider: _____

DOB: _____ NPI: _____

Phone Number: _____ Primary Care Provider: _____

Allergies: _____ Insurance Information: _____

Referral Status

☐ Is your patient currently on or have they failed oral iron?

☐ No, if oral iron was never tried and or failed, this will need to be ordered for 3 months. ☐ Yes, medication(s):_____

If yes, did they have an unsatisfactory response?

☐ Intolerant, describe reaction: _____ ☐ Other _____

Diagnosis & Required Information

Diagnosis and ICD 10 code(s):

☐ Iron deficiency anemia D50 ____

Secondary diagnosis, *please select one of the options below:*

(Not dialysis dependent)

☐ Stage 1 CKD N18.1

☐ Stage 2 CKD N18.2

☐ Stage 3 CKD N18.30

☐ Stage 3a CKD N18.31

☐ Stage 3b CKD N18.32

☐ Unspecified CKD with non-dialysis dependent N18.9

☐ Stage 4 CKD N18.4 *** Medicare guidelines require CKD4+

(Dialysis dependent)

☐ Stage 5 CKD N18.5

☐ End stage renal disease CKD N18.6

☐ Other: _____

Please include the following along with the order form:

☐ Patient face sheet

☐ CBC and iron panel results *(Must be within 28-days of scheduled treatment)*

☐ Provider notes that include supporting diagnosis

Medication Order

Drug: Venofer (iron sucrose) For prescribing information visit: Venofer® Dosing and Administration

☐ Not dialysis dependent - Venofer 200 mg IV x5 doses with at least one day apart over 14 days ☐ Other:_____

Labs:

☐ Complete Metabolic Panel, routine, ONCE every _____ ☐ Days ☐ Weeks ☐ Months

☐ CBC with Differential, routine, ONCE every _____ ☐ Days ☐ Weeks ☐ Months
(Re-draw CBC if out of the allowed 28-day reference period)

☐ Iron Panel, ONCE every_____ ☐ Days ☐ Weeks ☐ Months

☐ Other: _____

OSI hypersensitivity protocol: Solumedrol, Benadryl, or Famotidine, NS could be used in the event of a hypersensitivity reaction. Referring office will be notified if this occurs

Physician's Signature: _____ Date: _____

Provider Name: _____ Office Phone: _____ Office Fax: _____

Fax completed form to (503) 540-3105

Questions? Call us at (503) 540-9999

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