



PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F Ht: _____ Wt: _____ lbs kg
 Primary Language: _____ Allergies: _____

<ICD 10 CODE REQUIRED>

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE) SELECT PRIMARY and SECONDARY DX

Primary Diagnosis ICD 10 Codes

- D50.0 Iron deficiency anemia (IDA) secondary to blood loss (chronic)
- D50.8 other iron deficiency anemias
- D50.9 iron deficiency anemia, unspecified
- D63.1 Anemia in Chronic Kidney Disease (CKD)
- E61.1 Iron deficiency (excludes iron deficiency anemia)

Secondary for Venofer (iron sucrose)

- N18. _____ Chronic Kidney Disease (CKD) Stages 1-5, ESRD
- N18.9 CKD unspecified with non-dialysis dependent

Secondary Diagnosis ICD 10 code (Continued)

- K50. _____ Crohn's disease
- K51. _____ Ulcerative Colitis
- K90. _____ Malabsorption due to intolerance
- K91.2 Postsurgical malabsorption
- N18. _____ Chronic Kidney Disease (CKD)
- N92. _____ irregular menstruation
- T45.4X5A Adverse effect of iron and its compounds
- I50. _____ Heart Failure (HF)
- Other: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, lab results & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy
LABS RESULTS: CBC, iron panel, ferritin, transferrin saturation must indicate IDA for treatment approval **within last 28 days**

PRESCRIPTION

Pre-Medications

- Acetaminophen: 650 mg PO
- Cetirizine 10 mg PO
- Famotidine: _____ mg IV
- Dexamethasone _____ mg IV
- Ondansetron: 4 mg IV
- Methylprednisolone: _____ mg IV

Lab Orders

- CBC w/diff: every _____ weeks month
- CMP: ever _____ weeks month
- Other: _____ weeks months

Feraheme (ferumoxytol) (SELECT ONE)

- IV: infuse 510 mg x 2 doses with at least 3-8 days apart

Is your patient currently on or has failed oral iron? yes no

If yes, please note medication: _____

If no, oral iron will need to be trialed for at least 3 months

INFeD (iron dextran) (SELECT ONE)

- IV: infuse 1000 mg x 1 dose
- ** Test dose of 25 mg required if first administration over 5 minutes with an observation period of 60 minutes
- If there is no reaction, will infuse remaining dose of 975 mg over 60 minutes **

Injectafer (ferric carboxymaltose) (SELECT ONE)

- IV: infuse 750 mg x 2 doses with at least 7 days apart
- IV: infuse 750 mg weekly x _____ doses
- IV: infuse _____ mg weekly x _____ doses

Adverse Events: In the event of an adverse reaction occurring at Oregon Specialty Infusion clinic, OSI will utilize their adverse reactions protocol

Venofer (iron sucrose) ** indicated for the treatment of IDA in patients with CKD (SELECT ONE)

- IV: infuse 200 mg x 5 doses over two weeks with at least one day apart
- IV: infuse 200 mg every _____ weeks x _____ doses
- IV: infuse _____ mg x _____ doses with at least one day apart

PRESCRIBING INFORMATION

Prescriber Name: _____ Signature: _____
 Date: _____ NPI # _____ Specialty: _____
 Office phone #: _____ Office Fax #: _____