MEDICAL ASSOCIATES

Infusion Center
1500 Associates Drive • Dubuque, IA 52002
563-584-4370

Feraheme (ferumoxytol injection) ORDER FORM

Prerequisites to treatment – ensure the following information is complete and attached with referral: ☐
Demographics ☐ Prior Authorization ☐ Office/Progress Notes

PATIENT INFORMATION

Patient Name: _____ D.O.B._____ ☐Male ☐Female

Phone Number: _____ Allergies: _____

DIAGNOSIS

☐ Iron Deficiency Anemia ICD 10: _____

☐ Anemia ICD 10: _____

☐Other: _____ ICD 10: _____

PRE-MEDICATION

☐ Tylenol 1000mg PO ☐ Solu-Medrol 40mg IVP

☐ Cetirizine 10mg PO ☐ Solu-Medrol 125mg IVP

☐ Diphenhydramine 25mg PO ☐ Other: _____

MEDICATION

Feraheme

Dosing: ☐ IV 510mg/17mL (30mg/mL)

Frequency: ☐ x 2 doses separated by 3-8 days

Duration: ☐ Administer over 15 minutes

Route: ☐Peripheral IV per protocol ☐PICC capping per protocol ☐PORT capping per protocol

☐Monitor vitals baseline and post infusion

☐Other: _____

☐New Start ☐Continuation of therapy ☐Date of Last Dose (if applicable) _____

REFERRING PROVIDER INFORMATION

For questions regarding patient's care during the infusion, please contact:

Facility: _____ Fax: _____

Name 1st Point of Contact (must be available during infusion): _____

Phone: _____

Name 2nd Point of Contact (must be available during infusion): _____

Phone: _____

By referring to the Medical Associates Infusion Clinic, it is recognized and agreed upon that the referring specialist or delegate listed above will be available and responsive during the duration of the scheduled infusion appointment. This contact should be available to answer any questions and/or address concerns related to the care of the patient. The on-site provider within the Infusion Clinic will be responsible for urgent patient care needs during the infusion.

Ordering Provider Name (please print): _____

Ordering Provider Signature: _____ Date: _____

FAX NUMBER: 563-584-4232 **PHONE NUMBER**: 563-584-4370

Order valid for 1 year from date of signature unless otherwise specified.