Feraheme® (ferumoxytol) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)

____ ______________________

Patient Name **DOB**

___________________________ _________________

Allergies **Patient Phone**

Primary Diagnosis (must include ICD 10 code)
☐ Iron Deficiency Anemia______________ ☐ Iron Deficiency Unspecified______________
☐ Anemia, Unspecified ________________ ☐ Other Medical Necessity________________
Secondary Diagnosis (must include ICD 10 code)
☐ Adverse effect of biologic drug________________ ☐ Malabsorption________________
☐ Chronic kidney disease________________ ☐ Other Medical Necessity________________

Prescription Orders: Feraheme® (ferumoxytol)

Sig: Give 510mg IV over at least 30 minutes once weekly for 2 doses.

Monitor the patient for 30 minutes after infusion for signs of reaction including a blood pressure reading immediately prior to discharge.

Premeds: ____

____

Physician Name **Phone** **Fax**

____

Physician's signature **Date**

Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com

Updated 08/29/2019