AMERICAN INFUSION CARE
SPECIALTY INFUSION

Iron (Fereheme/Injectafer/Venofer)

Provider Order Form *rev. 1/2/2026*

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

☐ NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

☐ D50.0 Iron deficiency anemia secondary to blood loss (chronic)
☐ D50.8 Other iron deficiency anemias
☐ D50.9 Iron deficiency anemia, unspecified
☐ D63.1 Anemia in chronic kidney disease
☐ D64.9 Anemia, unspecified
☐ N18.3 Chronic kidney disease, stage 3 (moderate)
☐ N18.4 Chronic kidney disease, stage 4 (severe)
☐ N18.5 Chronic kidney disease, stage 5
☐ N18.9 Chronic kidney disease, unspecified
☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

☐ Acetaminophen (Tylenol) ☐500mg ☐650mg ☐ 1000mgPO
☐ Cetirizine (Zyrtec) 10mgPO
☐ Loratadine (Claritin) 10mgPO
☐ Diphenhydramine (Benadryl) ☐25mg ☐50mg ☐ PO ☐ IV
☐ Methylprednisolone (Solu-Medrol) ☐40mg ☐125mg IV
☐ Other: _____ Dose: _____ Route: _____

Lab Orders Required:

CBC with diff, ferritin, T Sat, Iron/TIBC
☐ Other: _____

Iron Therapy Administration (Select one):

☐ **Fereheme (ferumoxytol) IV**
☐ Infuse 510 mg IV over at least 15 minutes on Day 1. May repeat dose after _____ days.
☐ Infuse 1020 mg IV over 30 minutes as a single dose.
- No refills

☐ **Injectafer (ferric carboxymaltose) IV**
☐ Patients > 50kg: Two 750mg doses, 7 days apart
☐ Patients < 50kg: Two 15mg/kg doses, 7 days apart

☐ **Venofer (iron sucrose) IV** Dose (choose one):

Dose	Add to	Rates	Length
☐ 100 mg	100ml NS	200 ml/hr	30 minutes
☐ 200 mg	100ml NS	200 ml/hr	30 minutes
☐ 300 mg	250 ml NS	166.6 ml/hr	90 minutes
☐ 400 mg	250 ml NS	100 ml/hr	2.5 hours
☐ 500 mg	250 ml NS	62.5 ml/hr	4 hour

☐ Other Iron:_____

Frequency:

☐ Once ☐ every 2 - 3 days x _____ doses ☐ Daily x _____doses ☐ Weekly x _____doses ☐ Monthly x _____ dose
☐ **Refills:** ☐ zero ☐6 months ☐12 months ☐other: _____

Scan for more locations!

Post Treatment Observations: Flush with 0.9% sodium chloride at the completion of infusion. The patient is required to stay for 30 minutes following the first administration.
* Closely observe patients for signs and symptoms of hypersensitivity including monitoring of blood pressure and pulse during and after Feraheme, Venofer, and Injectafer administration for at least 30 minutes and until clinically stable following completion of each infusion.

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print) *Provider Signature* *Date*