Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

Office Fax # (_____) _____-_____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status New ☐ Order Change ☐

IV Iron Treatment Plan

Patient Name: _____ **Patient DOB** _____

☐ Diagnosis- Other Iron Deficiency Anemia ICD-10 Code D50.8

☐ Other Diagnosis-_____ ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date _____

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last infusion _____

** **Referring provider should attach hemoglobin and hematocrit results (minimum) in addition to any additional iron studies available for use in the insurance authorization process. H&H must have been obtained within the last 30 days.**

Indication for treatment:

☐ Oral iron ineffective ☐ Oral iron not tolerated ☐ Chronic kidney disease ☐ Oral iron drug interaction

Infusion (Month 1 to 12) Duration: 12 Months

☑ *Vital Signs BP/HR/Resp/SpO2/Temp*
Baseline on arrival to unit, upon completion of therapy, and prior to discharge

☑ Vital Signs
as needed if patient experiences adverse reaction until one hour after symptom resolution

Pre- Treatment Medications

Acetaminophen (Month 1 to 12)

☐ *650 mg, Oral, Tab, Day of Tx*
Comments: Administer 30 minutes before iron infusion

Decadron (Month 1 to 12)

☐ *4 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before iron infusion

SOLU-Medrol (Month 1 to 12)

☐ *40 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before iron infusion

☐ *125 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before iron infusion

Famotidine (Month 1 to 12)

☐ *20 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before iron infusion

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____

IV Iron Treatment Plan (Select One)

IV Iron (product selected per insurance formulary)

☐ IV-Iron: ferumoxytol, ferric carboxymaltose or iron sucrose. Dosed as listed, product selected per insurance formulary list:

____Ferumoxytol 510mg IV, 2 doses 7 days apart (Total Dose 1020 mg)

____Ferric carboxymaltose 750 mg IV, 2 doses 7 days apart (Total Dose 1500 mg)

____Iron sucrose 200 mg IV, 5 doses (Total Dose 1000 mg)

☐ Every 7 days ☐ Over 14-day period (frequency not to exceed every other day)

Iron Sucrose (Venofer)

☐ 200 mg, IV Piggyback, Day of Tx followed by _____additional dose(s) {Max=4}
Comments: Mix in 100 mL NS, infuse over at least 30 minutes. **Maximum dose is 1000mg in 5 divided doses over a 14-day period [Day 0,3,5,8, and 11**]. (Days may be adjusted to accommodate availability)

☐ 200 mg, IV Piggyback, Injection, Day of Tx followed by _____additional dose(s) {Max=4}
Comments: Mix in 100 mL NS, infuse over at least 30 minutes. **Doses to be administered every 7 days (weekly**)

Ferric Carboxymaltose (Injectafer)

☐ 750 mg, IV Piggyback, Day of Tx **[Greater Than or Equal To 50 kg]** followed by _____ additional dose(s) given 7 days apart {Max 1 additional dose}
Comments: Mix in 250 mL NS, infuse over at least 30 minutes.

☐ 15 mg/kg, IV Piggyback, Day of Tx **[Less Than 50 kg]** followed by _____additional dose(s) given 7 days apart {Max 1 additional dose}
Comments: Mix in NS to final concentration of 2-4 mg/mL, infuse over at least 30 minutes.

Ferumoxytol (Feraheme)

☐ 510 mg, IV Piggyback, Day of Tx **with a second dose to be given 7 days later**
Comments: Mix in 100 mL NS, infuse over at least 30 minutes.

☐ 510 mg, IV Piggyback, **x1 dose**
Comments: Mix in 100 mL NS, infuse over at least 30 minutes.

☑ Communication Order
Patients must stay in infusion area for 30 min post infusion. If vital signs normal may be discharged to home. If abnormal, call physician.

☑ Communication Order
If BP is greater than or equal to 160/100 hold infusion. If BP remains elevated after at least 2 reassessments at least 5 minutes apart, notify provider.

☑ Communication Order
If systolic BP is less than or equal to 90 hold infusion. If BP remains hypotensive after at least 2 reassessments at least 5 minutes apart, notify provider.

☑ Notify Provider
for fever/chills, chest pain, hypotension, hypertension, dyspnea, pruritis, urticaria, persistent flushing, Temperature > 100F or HR <50 or > 130

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

Ordering provider acknowledges responsibility for laboratory monitoring including but not limited to CBC, Ferritin, and Iron studies as clinically appropriate. Note: Iron studies are not recommended to be completed sooner than 30 days following the completion of the iron infusions.

Provider Initials: _____

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____Provider Name (please print)_____

Date_____Patient Name _____Patient DOB_____