Ferric Carboxymaltose (Injectafer)

Provider Order Form

Newport Superior Infusion
1501 Superior Ave, Suite 202
Newport Beach, CA 92663
Phone: 949-601-6001
Fax: 866-542-8631

PATIENT INFORMATION

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight lbs / kg: Height in / cm:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☐ Provide nursing care per Newport Infusion Standard Procedures

RECOMMENDED PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) 125mg IV

PRE-MEDICATION ORDERS

☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ famotidine (Pepcid) 20mg PO
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

THERAPY ADMINISTRATION

☑ **Ferric Carboxymaltose** (Injectafer) intravenous push or infusion

- Dilute up to 1000mg of iron in no more than 250mL sterile 0.9% NaCl (≥2 mg iron/mL)
- Dose (≥50 kg)
  ☐ 750 mg x2 doses (at least 7 days apart)
  ☐ 15 mg/kg x1 dose (max 1000mg)
- Dose (<50 kg)
  ☐ 15 mg/kg x2 doses (at least 7 days apart)
- Route: ☐ IV infusion ☐ IV push
- Rate: Choose one
  ☐ IV infusion: Administer over at least 15 minutes
  ☐ IV push (750 mg): ~100 mg (2 mL) / min
  ☐ IV push (1,000 mg): Administer over 15 minutes

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Date**

Provider Signature