Cumberland Vital Care
Fax Referral To:
(931) 456-4857
Direct Phone: (931) 456-0680

CUMBERLAND VITAL CARE
PHARMACEUTICAL COMPOUNDING & INFUSION SERVICES

FERAHEME ORDER FORM

Date:_____
Patient Name: _____
Date of Birth: _____
Allergies: _____
Weight: _____ lbs OR _____ kg

ICD-10 Code:
- ☐ D50.0 Iron deficiency anemia secondary to blood loss (chronic)
- ☐ D50.8 Other iron deficiency anemia
- ☐ D50.9 Iron deficiency anemia, unspecified
- ☐ D63.1 Anemia in chronic kidney disease (Code CKD Stage First)
- ☐ D63.8 Anemia in other chronic disease (Code underlying disease first)
- ☐ Other:_____

Therapy Status

Please check any of the following that apply:

- ☐ *Patient has previously failed oral iron therapy.*
- ☐ *Patient has previously been treated with Feraheme or other IV iron.*
- ☐ *Patient has previously experienced an adverse reaction from an iron therapy.*
- ☐ *Patient has chronic renal disease.*

Provider Information

Ordering Provider: _____
Provider NPI: _____
Provider Phone: _____
Provider Fax: _____
Provider Address: _____

MEDICATION ORDER

Feraheme	☐ Feraheme 510mg IV x two total doses, separated by 3-8 days.	✓ *Patient will be observed for signs and symptoms of hypersensitivity during infusion and for at least 30 minutes post infusion.*	**Please include the following lab results required for infusion:** ✓ *Hemoglobin and Hematocrit within past 60 days* ✓ *Iron Studies within past 60 days*

PRE-MEDICATIONS

Oral
- ☐ Acetaminophen: ___325mg ___500mg __650mg
- ☐ Loratadine: 10 mg
- ☐ Cetirizine: 10mg
- ☐ Diphenhydramine: ___25mg ___50mg
- ☐ Famotidine: ___20mg ___40mg
- ☐ Ibuprofen: ___200mg ___400mg ___600mg
- ☐ Ondansetron: ___4mg ___8mg
- ☐ Other_____

IV
- ☐ Dexamethasone: ___4mg ___8mg
- ☐ Diphenhydramine: ___25mg __50mg
- ☐ Famotidine: ___20mg ___40mg
- ☐ Methylprednisolone 125mg
- ☐ Hydrocortisone 100mg
- ☐ Ondansetron: ___4mg ___8mg
- ☐ Other_____

LAB ORDERS (Please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Ofice Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

Surveillance lab ordering, and monitoring is the responsibility of the prescriber

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date