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

CVC
CUMBERLAND VITAL CARE
PHARMACEUTICAL COMPOUNDING & INFUSION SERVICES

INJECTAFER 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 Injectafer 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

Injectafer

- ☐ Weight less than 50kg: Administer Injectafer 15mg/kg IV x two doses at least seven days apart, not to exceed max dose of 1,500mg per treatment course.
- ☐ Weight greater than or equal to 50kg: Administer Injectafer 750mg IV x two doses at least seven days apart for a total of 1,500mg per treatment course.
- ☐ Alternative dosing for adult patients weighing 50kg or more: Administer Injectafer 15mg/kg IV up to a maximum of 1,000mg as a single dose treatment course.

✓ 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)

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

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

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