BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

IRON
INFUSION ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Patient Weight: _____ lbs. (required) Allergies: _____

Primary ICD-10: _____

- ☐ Iron Deficiency Anemia
- ☐ Iron Deficiency Unspecified
- ☐ Iron Deficiency Anemia secondary to Inadequate Dietary Iron Intake
- ☐ Other medical necessity: _____

Secondary ICD-10: _____

- ☐ Adverse effect of other drug (oral iron intolerance or not adequate)
- ☐ End-stage Renal Disease
- ☐ Intestinal Malabsorption
- ☐ Chronic Kidney Disease
- ☐ Other medical necessity: _____

FERAHEME THERAPY ORDER

☐ Feraheme® 510 mg IV once followed by a second 510 mg IV dose 3 to 8 days later

Note: may reorder for persistent or recurrent iron deficiency anemia. Order hemoglobin and hematocrit, serum ferritin and transferrin saturation, and serum iron and total iron binding capacity at least 1 month following the second infusion.

INJECTAFER THERAPY ORDER

****If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first****

☐ **Patient weighing less than 50kg (110 lbs.)**
Dose: Injectafer 15mg/kg IV
Frequency: Give 2 doses at least 7 days apart not to exceed 1500mg

☐ **Patient weighing 50kg (110 lbs.) or greater**
Dose: Injectafer 750mg IV
Frequency: Give 2 doses at least 7 days apart not to exceed 1500mg

MONOFERRIC THERAPY ORDER

****If the patient has Cigna, Humana, or UHC, the patient must try and fail Feraheme first****

☐ **Patient weighing less than 50kg (110 lbs.)**
Dose: Monoferric 20mg/kg IV x 1 dose

☐ **Patient weighing 50kg (110 lbs.) or greater**
Dose: Monoferric 1000mg IV x 1 dose

VENOFER THERAPY ORDER

☐ Venofer 200mg IV - Administer 5 doses over a 14 day period
☐ Venofer 200mg IV weekly x 5 weeks
☐ Other: _____

Other orders: _____
Lab orders: _____ **Frequency:** _____
Required labs to be drawn by: ☐ Biocare Infusion ☐ Referring physician

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen® 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x 1
  - 15-30kg (33-66lbs): EpiPen® 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x 1
- Solu-Medrol 125mg IV as needed (adult), refer to provider orders or policy for pediatric dosing
- NS 250-500 mL IV bolus as needed (adult), refer to provider orders or policy for pediatric bolus

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient. Based on patient insurance coverage and our clinical therapeutic guidelines policy, we reserve the right to choose a therapeutically equivalent alternative.

Provider Name: _____ Signature: Date: _____
Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____
☐ Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

COMPREHENSIVE SUPPORT FOR IRON THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes (H&P) to support primary diagnosis
- ☐ Does the patient have an intolerance, contraindication, or documented tried and failed use of oral iron? ☐ Yes ☐ No
- ☐ Does the patient have an intolerance or documented tried and failed use of an IV iron product? ☐ Yes ☐ No If yes, which drug(s)? _____
- ☐ Labs showing iron deficiency anemia attached
- ☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

- ☐ **Labs indicating iron deficiency - please attach**

Biocare Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance