Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

Iron Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ☐ Iron deficiency anemia secondary to blood loss (chronic) ICD-10: D50.0
- ☐ Other Iron deficiency anemias ICD-10: D50.8
- ☐ Iron deficiency anemia, unspecified ICD-10: D50.9
- ☐ Anemia in neoplastic disease ICD-10: D63.0
- ☐ Anemia in chronic kidney disease ICD-10: D63.1
- ☐ Anemia in other chronic diseases ICD-10: D63.8
- ☐ Other ICD-10:_____

ORDER DETAILS:

- ☐ **VENOFER:** **(Note-Preferred by most insurance companies)** 200 mg IV X 5 doses, given within 14 days
- ☐ **FERAHEME:** 510 mg IV x 2 doses, separated by 3-8 days
- ☐ **INJECTAFER:**
  - ☐ Patient weighing less than 50kg (110lbs), 15mg/kg IV x 2 doses, separated by 7 days, not to exceed 1500mg
  - ☐ Patient weighing 50kg (110lbs) or greater, 750mg IV x 2 doses, separated by 7 days, not to exceed 1500mg
- ☐ **OTHER:**_____

PRE-MEDICATIONS:

- ☐ Acetaminophen 650mg PO
- ☐ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- ☐ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port or Picc Line
FLUSHING: 10 mls NS and Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion
LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

Revised: 03/2025

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Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

- ☐ Signed Provider orders (page 1)
- ☐ Patient demographic and insurance information
- ☐ Patient's current medication list
- ☐ Supporting recent clinical notes and H&P (to support primary diagnosis)
- ☐ Does the patient have an intolerance, contraindication or documented tried and failed use of oral iron product?
  - ☐ Yes OR ☐ No
- ☐ Does the patient have an intolerance or documented failed use of any IV iron products?
  - ☐ Yes OR ☐ No
  - ☐ IF yes, which Drugs?_____
- ☐ Labs supporting iron deficiency diagnosis (please attach with referral)
- ☐ Additional or other medical necessity:_____

Additional Pre-Screening Assessment:

- ☐ Labs indicating Iron Deficiency - please include results

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