

PATIENT INFORMATION

PATIENT NAME: _____ PHONE: _____

DATE OF BIRTH: _____ SEX: ☐ M ☐ F HEIGHT: _____ WEIGHT: _____ ☐ LBS ☐ KG

ALLERGIES: _____ PREFERRED CLINIC: _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL**DIAGNOSIS & CLINICAL DOCUMENTATION**☐ D50.0 Iron Deficiency Anemia secondary to blood loss☐ D50.9 Iron Deficiency Anemia☐ ICD-10 CODE: _____ DESCRIPTION: _____**REQUIRED DOCUMENTATION**☐ Insurance
Information☐ List of
Medications☐ Most recent
History & Physical☐ Tried & Failed
Therapies☐ Other iron studies
if available☐ Recent hemoglobin, hematocrit within 30 days**MEDICATION ORDER**☐ Feraheme (ferumoxytol) 510 mg IV in 250 ml NS over 30 minutes followed by second dose of 510 mg IV in 250 ml NS over 30 minutes 3 – 8 days after initial dose

Patient to be observed for 30 minutes following infusion.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ NPI #: _____

EMAIL: _____ PHONE: _____ FAX: _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING
PHYSICIAN: _____ CONTACT NAME: _____
(IF APPLICABLE)SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN