REAL INFUSIONS
Proud Affiliate of Real Medix, LLC

IRON DEFICIENCY ANEMIA

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ EMAIL: _____

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Medication List 5. Recent Iron Panel / H&H
6. Intolerance or unsatisfactory response to oral Iron supplementation

PRIMARY DIAGNOSIS

☐ D50.0 Iron deficiency anemia secondary to blood loss (chronic)
☐ D50.8 Other iron deficiency anemias
☐ D50.9 Iron deficiency anemia, unspecified
☐ D63.1 Anemia in chronic kidney disease
☐ D64.9 Anemia, unspecified
☐ N18.3 Chronic kidney disease, stage 3 (moderate)
☐ N18.4 Chronic kidney disease, stage 4 (severe)
☐ N18.5 Chronic kidney disease, stage 5
☐ N18.9 Chronic kidney disease, unspecified
☐ Other _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: There are no recommended standard pre-meds
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ **Injectafer-**750mg IV × 2 doses Separated by ~7 days Covers: D50.0, D50.8, D50.9 Requires 2 failed trials of Infed/Ferrlecit/Venofer for some payers
☐ **Sodium Ferric Gluconate (Ferrlecit) -**125mg IV × 2 doses Separated by ~3 days Covers: D50.0, D50.8, D50.9 | First-line for non-CKD
☐ **Venofer -** 200mg IV × _____ doses (5 dose standard) Separated by ~5 days (Covers ONLY: N18.3, N18.4, N18.5, N18.9 | Denied for D50.x alone.
☐ **Monoferric -** 1,000mg IV × 1 dose (or _____ mg) Covers: D50.0, D50.8, D50.9 | most payers require CKD (N18.x)
☐ **Feraheme -** 510mg IV × 2 doses Separated by ~5 days Covers: D50.0, D50.8, D50.9 | Requires 2 failed trials of Infed/Ferrlecit/Venofer
☐ Other _____

FIRST DOSE?: ☐ Yes ☐ No ☒ Refill x12 months unless otherwise noted _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC
☑ Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
☐ Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ EMAIL: _____

CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

✖ _____ _____

PROVIDER SIGNATURE DATE