



FERAHEME® (ferumoxytol injection) ORDER FORM **STAT REQUEST**
(* - Required Fields) (*REASON MUST BE PROVIDED BELOW)

<input type="checkbox"/> New Referral	<input type="checkbox"/> Order Renewal	<input type="checkbox"/> Medication/Order Change
<input type="checkbox"/> Benefits Verification Only	<input type="checkbox"/> Discontinuation Order	

Locations:

-----Oklahoma-----

Tulsa

PATIENT INFORMATION			
NAME*:	DOB*:	SEX:	M F
ADDRESS:	PHONE:		
WEIGHT: LBS KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION			
PHYSICIAN NAME*:	PRACTICE NAME:		
ADDRESS:	OFFICE CONTACT*:		
PHONE:	FAX:	EMAIL (FOR UPDATES):	

FERAHEME ORDER*: **ICD-10*:** _____

(SELECT ONE OF THE FOLLOWING)

Initial 510 mg dose followed by a second 510 mg dose 3 to 8 days later

Physician Signature* _____ Date*(Order is Valid for One Year) _____
Infusion will be administered per policy and protocols

REQUIRED DIAGNOSIS:

Iron Deficiency Anemia

Chronic Kidney Disease (CKD)

Other _____

Secondary/causal diagnosis code: _____

***STAT REASON:**
(STAT request will be assessed per MP policy and protocol)

REQUIRED DOCUMENTATION CHECKLIST:

Patient Demographics

Insurance Card/Information

Clinical/Progress Notes supporting DX

Current Medication List and H&P

Ferritin, w/in the past 3 months

Last Infusion/Injection Date: _____

STANDING LAB ORDERS: CMP CBC

Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS: