

**Patient Information**

Patient Name:	DOB:	Phone:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Patient Address:	Email:	Insurance:	

**Additional Information Needed**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Fax front/back of insurance card | <input type="checkbox"/> Fax clinical/progress notes | <input type="checkbox"/> Fax labs                 |
| <input type="checkbox"/> Fax patient demographics         | <input type="checkbox"/> Fax current medication list | <input type="checkbox"/> Fax TB and Hep B results |

**Diagnosis and Clinical Information**
**Diagnosis (ICD-10):**

- |   |   |
|---|---|
| <input type="checkbox"/> D50.0 Iron Deficiency Anemia Secondary to Blood Loss | <input type="checkbox"/> D50.8 Other Iron Deficiency Anemias    |
| <input type="checkbox"/> D50.9 Iron Deficiency Anemia, Unspecified            | <input type="checkbox"/> D63.1 Anemia in Chronic Kidney Disease |
| <input type="checkbox"/> Other: Code: _____ Description: _____                |   |

**Clinical Information:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> New Therapy Induction   | <input type="checkbox"/> Therapy Change                         | <input type="checkbox"/> Therapy Continuation |
| <input type="checkbox"/> Patient Weight: _____ lbs / _____ kg  | <input type="checkbox"/> Patient Height: _____ in / _____ cm    |   |
| <input type="checkbox"/> Allergies: _____  |   |   |
| <input type="checkbox"/> Therapies Tried and Failed: _____   |   |   |
| <input type="checkbox"/> TB Test: Date: _____ Results: _____   | <input type="checkbox"/> Hep B Test: Date: _____ Results: _____ |   |
| <input type="checkbox"/> Does Patient have non-dialysis dependent chronic kidney disease? <input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |
| <input type="checkbox"/> Is patient currently on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No                                |   |   |

**Lab Orders**

- 
- CBC
- 
- Ferritin
- 
- Iron/IBC
- 
- 
- Other: \_\_\_\_\_

**Lab Orders to be done by**

- 
- Oklahoma Infusion Services
- 
- 
- Referring Provider

**Prescription Information**

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Feraheme | <input type="checkbox"/> Initial Dose: 510mg                               |
|                                   | <input type="checkbox"/> Second Dose: 510mg 3 to 8 days after Initial Dose |

**Pre-Medication Orders**

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> Solu-Cortef 50-100mg SIVP        | <input checked="" type="checkbox"/> Benadryl 25mg PO PRN |
| <input checked="" type="checkbox"/> Tylenol tablet 500-1000mg PO PRN | <input type="checkbox"/> Other: _____                    |

**Standing Orders for Adverse Reactions**

- |  |   |
|--|---|
| <input checked="" type="checkbox"/> Stop infusion and initiate NS bolus                    | <input checked="" type="checkbox"/> Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis    |
| <input checked="" type="checkbox"/> Notify supervising physician and ordering provider     | <input checked="" type="checkbox"/> Oxygen 2-5L nasal cannula                       |
| <input checked="" type="checkbox"/> Solu-Cortef 100mg SIVP signs of adverse reaction       | <input checked="" type="checkbox"/> Albuterol 2.5mg inhaled PRN for chest tightness |
| <input checked="" type="checkbox"/> Benadryl 25mg SIVP for hives or bronchial inflammation | <input type="checkbox"/> Other: _____   |

**Prescriber Information**

Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:

Prescriber's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.*