Infusion Center
Kennebunk · Portsmouth · Scarborough · Topsham
Phone: 207-303-3225 Fax:207-692-2473

IV Iron Replacement Order Form

Patient Name:____ **DOB:**________________

Diagnosis: ______________________________________ Diagnosis Code:________________

Height: _____(cm) Actual Weight: ____(kg) Allergies: ________________________________

Please list any premeds needed here:____

____

***** Laboratory requirements for the administration of IV Iron (Labs are required to be within 30 days of treatment):**

- **Ferritin < 100mg/dL**

  OR

- **TSAT < 20%**

***** Monoferric is the preferred Iron Product for New England Cancer Specialists**.

Other agents will be considered based on insurance restrictions or patient intolerance to Monoferric

Monoferric (Ferric Derisomaltose) CPT J1437:

☐ Dose: 1000 mg IV

☐ **Other Iron Product.**

Drug Name____________________________

Drug Dose_________**mg**

Frequency___________________________

* **In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.**

Provider Name: ____

Provider Signature: ____ Date: ____________

Phone: ________________ Fax: ________________ Pager: ________________