NORTH TEXAS INFUSION CENTERS

Feraheme® (ferumoxytol) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)

_____ _____
Patient Name **DOB**

_____ _____
Allergies **Patient Phone**

Primary Diagnosis (must include ICD 10 code)
☐ Iron Deficiency Anemia_____ ☐ Iron Deficiency Unspecified_____
☐ Anemia, Unspecified _____ ☐ Other Medical Necessity_____
Secondary Diagnosis (must include ICD 10 code)
☐ Adverse effect of biologic drug_____ ☐ Malabsorption_____
☐ Chronic kidney disease_____ ☐ Other Medical Necessity_____

Prescription Orders: Feraheme® (ferumoxytol)

☐ Sig: Give 510mg IV over at least 30 minutes once weekly for 2 doses.

☐ ***Monitor the patient for 30 minutes after infusion for signs of reaction including a blood pressure reading immediately prior to discharge.***

Premeds: _____

_____
Physician Name **Phone** **Fax**

_____
Physician's signature **Date**

Fax completed form to (214) 887-0436.Contact us directly at: (214) 276-5642
Or visit us online at www.ntinfusioncenters.com