Atrium Health

Atrium Health Infusion Center

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390
	☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390
	☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

Iron Replacement Infusion Order (Revised 11/11/2025)

All orders with a √ will be placed.

Patient Demographics:

Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:

Allergies: (please list all allergies or attach list)

☐ NKDA

Diagnosis: (Select Primary AND Secondary Diagnosis)

☐ D50.8 - Other iron deficiency anemias	☑ Secondary Diagnosis **REQUIRED**:
☐ D50.0 - Iron deficiency anemia secondary to blood loss (chronic)	☐ Other:

Required Documentation: (*required prior to scheduling*)

Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:
Complete Medication List - Include all tried and failed meds	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Treatment Parameters:

☑ Required labs:
- CBC within 90 days PRIOR to treatment. (**fax labs with order**)

Nursing Communication:

☑ Start PIV/Access CVC and flush device per approved Atrium Health protocol.

☑ Obtain vital signs PRE-treatment, POST-treatment, and PRN during treatment.

☑ Observe patient for signs and symptoms of hypersensitivity DURING and AFTER Injectafer, Venofer, or Feraheme administration for AT LEAST 30 minutes, and until clincally stable following completion of administration.

Pre-Medications: (Administer all pre-medications 30mins prior to treatment)

☐ Acetaminophen (Tylenol) 650mg PO ONCE

☐ Diphenhydramine (Benadryl) 25mg PO ONCE

☐ Diphenhydramine (Benadryl) 25mg IV ONCE

☐ Methylprednisolone (Solu-Medrol) 125mg IV ONCE

☐ Hydrocortisone sodium succinate (Solu-Cortef) 100mg IV ONCE

Select ONE of the following:

☐ Give pre-medications prior to Iron Dextran (INFED) ONLY.

☐ Give pre-medications prior to ANY IV preparation.

Infusion Therapy:

SELECT ALL IRON PRODUCTS THAT THE PATIENT MAY RECEIVE.

☐ Ferric Carboxymaltose (Injectafer) - Select ONE dosing option below (MUST check ONE option)

- ☐ 750mg IV weekly x 2 doses
- ☐ 750mg IV ONCE
- ☐ 15mg/kg (< 50kg) IV weekly x 2 doses
- ☐ 15mg/kg (<50kg) IV ONCE
- ☐ Do Not Authorize: (reason required) ☐ Intolerance ☐ Inadequate Response ☐ Other:

☐ Ferumoxytol (Feraheme) - Select ONE dosing option below (MUST check ONE option)

- ☐ 510mg IV weekly x 2 doses
- ☐ 510mg IV ONCE
- ☐ Do Not Authorize: (reason required) ☐ Intolerance ☐ Inadequate Response ☐ Other:

☐ Iron Sucrose (Venofer) - Select ONE dosing option below (MUST check ONE option)

- ☐ 200mg IV three times a week x 5 doses
- ☐ 300mg IV weekly x 2 doses followed by 400mg IV weekly x 1
- ☐ Do Not Authorize: (reason required) ☐ Intolerance ☐ Inadequate Response ☐ Other:

☐ Iron Dextran (Infed) - Select ONE dosing option below (MUST check ONE option)

- ☐ 1000mg IV once over (SELECT DURATION BELOW)
- ☐ _____mg (Calculated Iron Deficit)

*Total Dose Calculation: Dose (mL) = 0.442 (Desired Hgb) x LBW + (0.26 x LBW)
Dose (mg) = Dose (mL) x 50mg/mL
LBW = Lean body weight (kg) - Males: 50kg + (2.3kg x each inch height over 5ft)
Females: 45.5kg + (2.3kg x each inch height over 5ft)

- ☐ Do Not Authorize: (reason required) ☐ Intolerance ☐ Inadequate Response ☐ Other:

Select Infusion Duration:

☐ 1 hour (may use for doses ≤ 1000mg; NOT to be used for doses > 1000mg. ☐ 4 hours

Select if Test Dose is Needed:

☐ No

☐ Yes - 25mg IV over 1 minute. Wait for one hour; if no reaction, infuse remaining dose over indicated duration.

☑ **Atrium Health will authorize the payer preferred iron product**

Supportive Care Medications:

☑ Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.

☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.

☑ Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:

☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

Prescriber Information:

Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted

Signature:	Date: