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Washington Township Infusion Center
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Feraheme® (Ferumoxytol) Order Form
Epic Referral: REF193

Patient Name: _____ **DOB:** _____

Address: _____

Phone: _____

ICD-10 Diagnosis Codes (2 required – 1 primary, 1 secondary):

<u>Primary Diagnosis Codes (pick one)</u>	<u>Secondary Diagnosis Codes (pick one)</u>
<input type="checkbox"/> D50.0 – Iron deficiency anemia secondary to blood loss	<input type="checkbox"/> K90.9 – Intestinal malabsorption
<input type="checkbox"/> D50.9 – Iron deficiency anemia, unspecified	<input type="checkbox"/> K91.2 – Postsurgical malabsorption
<input type="checkbox"/> D50.8 – Other iron deficiency anemias	<input type="checkbox"/> T45.4X5D – Adverse effect of iron, subsequent encounter
<input type="checkbox"/> O99.011 – Anemia complicating pregnancy 1 st trimester	<input type="checkbox"/> Z87.19 – Personal history of other digestive disease
<input type="checkbox"/> O99.012 – Anemia complicating pregnancy 2 nd trimester	
<input type="checkbox"/> O99.013 – Anemia complicating pregnancy 3 rd trimester	

OR for Anemia related to chronic kidney disease:

<u>Primary Diagnosis Codes (pick one)</u>	<u>Secondary Diagnosis Codes (pick one)</u>
<input type="checkbox"/> N18.3 Chronic kidney disease, stage 3 (moderate)	<input type="checkbox"/> D50.0 – Iron deficiency anemia secondary to blood loss
<input type="checkbox"/> N18.4 Chronic kidney disease, stage 4 (severe)	<input type="checkbox"/> D50.8 – Other iron deficiency anemias
<input type="checkbox"/> N18.5 Chronic kidney disease, stage 5	<input type="checkbox"/> D50.9 – Iron deficiency anemia, unspecified
<input type="checkbox"/> N18.6 End stage renal disease	<input type="checkbox"/> D63.1 – Anemia in chronic kidney disease

Rx:

Feraheme (ferumoxytol) 510 mg in 50 mL 0.9% NaCl IV over 15 minutes

Frequency/# of doses: One dose Weekly x 2 doses

Baseline labs must be included with the order (or available through Epic). Please note: follow-up iron labs should be completed ≥ 4 weeks following last dose to evaluate full effect of iron repletion.

Port/PICC care per protocol will be performed if applicable including heparin flush (500 units/5mL) and cathflo (2 mg) PRN for patients with a port

Prescriber Printed Name: _____

Prescriber Full Address: _____

Office Phone Number: _____ **Office Fax Number:** _____

Prescriber Signature: _____ **Date:** _____