

VENOFER (IRON SUCROSE) ORDER FORM

Patient Name:		DOB:	
Mobile Number	Patient Weight:	kg	Patient height: In

Allergies

PROVIDER INFORMATION

Provider Name		Provider NPI:	
Signature:		Date:	
Contact Name:	Phone:	Fax:	

Prerequisites to treatment — ensure the following information is complete and attached with referral:

- ☐ Demographics
 ☐ Labs and tests supporting diagnosis
 ☐ Office/progress notes

DIAGNOSIS (Provider must specify)

- ☐ Iron Deficiency Anemia, ICD 10: D50.9.
 ☐ CKD: Stage____, ICD 10: N18 _____.
- ☐ Other underlying disease:

Secondary Diagnosis:

- ☐ Anemia in CKD, ICD 10: D63.1
 ☐ Anemia in Chronic Disease, ICD 10: D63.8

PRE-MEDICATION (Not typically indicated)

- ☐ Acetaminophen (Tylenol) 500 mg PO
 ☐ Famotidine 20 mg IV
 ☐ Cetirizine 10 mg PO
- ☐ Methylprednisolone (Soli-I-Medrol) 125mg IV
 ☐ Benadryl 25mg PO

Other:	Dose:	Route:
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Medication

Medication	Dose	Route	Frequency
Venofer	☐ 100mg ☐ 200mg ☐ 300mg	IV	☐ x doses (not to exceed total of 1,000mg per course)

- ☐ New Start Therapy
 ☐ Continuation of Therapy
 Date of last dose (if applicable):

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified
 Please fax your order to one of the following locations.

One Care Infusion Pharmacy
 2025 Chicago Ave, STE A3
 Riverside, CA 92507
 Ph: 951-900-1120
 Fax: 951-900-1125

One Care Infusion Pharmacy
 907 W Coal Ave
 Gallup, NM 87301
 Ph: 505-726-4155
 Fax: 505-726-4304