BluHaven HEALTH

IV Iron Referral Form

Fax: (984) 370-2352
Phone: (984) 370-2350
Email: connect@bluhaven.com

Patient Information

Name: _____ DOB: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Weight: _____ ☐ lbs ☐ kgs

Allergies: ☐ NKDA ☐ _____

Required Documentation Insurance Card | History & Physical | Patient Demographics | Most Recent Labs | Medication List | Tried and Failed Therapies (including duration)

Primary Diagnosis

☐ ICD-10 Code: _____

Order Information

Pre-Medications

☐ Per infusion clinic protocol:

- ☐ acetaminophen (Tylenol) ☐ 500mg PO ☐ 650mg PO ☐ 1000mg PO
- ☐ diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
- ☐ methylprednisolone (Solu-Medrol) ☐ 40mg IV ☐ 125mg IV

☐ Provider Prescribed: _____

Primary Medication Order

☐ Ferumoxytol (Feraheme) intravenous solution, initial 510mg infusion followed by a second 510mg infusion 3-8 days later

☐ Ferric carboxymaltose (Injectafer) intravenous infusion

- ☐ Patients > 50kg: Two 750mg doses, 7 days apart
- ☐ Patients < 50kg: Two 15mg/kg doses, 7 days apart

☐ Iron sucrose (Venofer) intravenous infusion

Dose	*Add to*	*Rates*	*Length*
☐ 100mg	100ml NS	200ml/hr	30 min
☐ 200mg	200ml NS	200ml/hr	60 min
☐ 300mg	250ml NS	166.6ml/hr	90 min
☐ 400mg	250ml NS	100ml/hr	2.5 hrs
☐ 500mg	250ml NS	62.5ml/hr	4 hrs

Frequency:

☐ Once ☐ Every 2-3 days x _____ doses

☐ Daily x _____ doses ☐ Weekly x _____ doses

☐ Monthly x _____ doses ☐ Other _____

☐ Other: _____

☑ Refill x12 months unless otherwise noted: _____

Line Use/Care Orders

☐ Flush with 0.9% sodium chloride at infusion completion ☐ Patient required to stay for 30 min observation period

☐ Other Flush Orders: Please fax other line care orders if checking this box.

Provider Information

Name: _____ Office Contact: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____ NPI: _____

I authorize BluHaven Health and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this order and any future related orders for the patient listed above.

Provider Signature *Date*