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# INFUSION ORDER FORM

Date:_________________ Referring provider: _________________________________________

Referring provider phone:_______________________ Fax:_______________________________

Patient name: _______________________________________ DOB: ________________________

Allergies: __________________________________________________________________________

Diagnosis: ___________________________________ ICD 10 Code: ________________________

***PLEASE SEND A COPY OF DEMOGRAPHICS, MEDICATION LIST, ALLERGIES AND RESULTS OF MOST RECENT CBC AND IRON PANEL as some insurance carriers will require review prior to approval of erythropoetin-stimulating agents and iron infusions.

**IV Hydration**

D5LR ( ) 1 L at 1000 ml/hr for 1 hour

D5LR ( ) 2 L at 1000 ml/hr for 2 hour

**IV Medication**

( ) metoclopramide (Reglan) 10 mg IVP

( ) promethazine (Phenergan) 25 mg IVP

( ) ondansetron (Zofran) 8 mg IVP

( ) 1 L standard banana bag containing:

D5 ½ NS with 2 gm magnesium sulfate, 100mg thiamin, 1 mg folic acid, 10ml multivitamin

( ) epoetin alfa-epbx (Retacrit) 10,000 units SQ weekly prn Hgb <10.

( ) darbepoetin alfa (Aranesp) 0.75 mcg/kg every 21 days prn Hgb <10.

( ) ferric carboxymaltose (Injectafer) 750mg in 100ML NS weekly x 2 doses

( ) iron sucrose (Venofer) 200mg in 100ML NS 48 hours apart x 2 doses

( ) Other: __________________________________________________________________________

****AMERIGROUP IRON** patients only: Must document when oral iron was initiated (ex. Prenatal w/iron) and trial a minimum of 4 weeks prior to authorization for infusion. Ferritin and iron saturation required within 4 weeks of order.**

**Labs**

( ) CBC ( ) CMP ( ) TSH ( ) INR ( ) Other:_____________________________________

( ) Fax results to _______________________ ( ) Call stat results to _______________________

Additional comments: _____________________________________________________________

__________________________________________________________________________________

_________________________________ _____________ _____________

PHYSICIAN SIGNATURE DATE TIME

Please fax form to **563-345-4326** or we are happy to assist you over the phone at 563-345-4325.

Check out our referral link at **www.iacancer.com**

Thank you for your referral and we look forward to working with you!