Fax: 832-895-4040
Phone: 832-895-5000
E-mail: intake@adaptivinfusion.com

adaptIV infusion

Monoferric (ferric derisomaltose)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one)*: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: ____________________ DOB: __________

NKDA ☐ Allergies: ____________________ Weight ______ *Please specify:* ☐ lbs ☐ kg Height: ______

Patient Status *(check one)*: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: __________ Next Due Date: __________

ICD-10 code (required): __________ ICD-10 description: ____________________

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

DIAGNOSIS

☐ Iron Deficiency Anemia
☐ ______ ____________________

PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ ____________________
☐ ____________________

MONOFERRIC (FERRIC DERISOMALTOSE) ORDERS

- Dose & Frequency:
  - ☐ 1,000mg by IV infusion over at least 20 minutes (patients 50kg or more)
  - ☐ 120mg/kg actual body weight by IV infusion over at least 20 minutes (patients less than 50kg)
  - ☐ ____________________

PATIENT WEIGHT

______ lbs.
______ kg

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: ____________________ Referral Coordinator Email: ____________________

Ordering Provider: ____________________ Provider NPI: ____________________

Referring Practice Name: ____________________ Phone: __________ Fax: __________

Practice Address: ____________________ City: __________ State: ______ Zip Code: ______

Provider Name (Print) ____________________ *Provider Signature* ____________________ *Date* __________

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK