FirstHealth OF THE CAROLINAS

7096.08.16141.01 Sunset Date: 6/2024

OP Carboxymaltose (Injectafer) Referral

3POREF001

Place Patient Label Inside This Box

***** This section refers to the entire plan. If individual orders need a different interval, please indicate in each section below*****

Version 6/2021

Date of Infusion: _____

Patient Name: _____

Patient SSN (if available): _____

Insurance Name: _____

Secondary Insurance: _____

Diagnosis Code: _____

Diagnosis Code Description: _____

Lead Physician _____

Date of Birth: _____

Contact Number: _____

Policy Number: _____

Policy Number: _____

Precertification: ☐ Initiated ☐ Complete

Location to be Performed:
☐ Moore Regional Hospital (MRH)
☐ Montgomery Memorial Hospital (MMH)

Interval _____ Day _____ of every _____ month

Minimum Separation _____ days / weeks (circle one)

Next Due Date _____

Duration: ☐ Until discontinued ☐ ____ Treatments
☐ Until _____

Nursing Orders	Interval	Duration
☐ Vital Signs Routine	_____	_____
☐ Insert peripheral IV Once	_____	_____
Picc Access And Flush Orders		
☐ PICC Line Access Once	_____	_____
☐ Heparin, porcine (PF) 10 unit/mL injection 50 Units 50 Units, intravenous Once	_____	_____
Vascular Access Device (cvc) Access and Flush Orders		
☐ Central Venous Catheter (CVC) access Once	_____	_____
☐ Heparin, porcine (PF) injection 500 units, IV once	_____	_____
Labs		
☐ CBC		
☐ Comprehensive metabolic panel		
Pre-Medications		
☐ Sodium chloride 0.9 % infusion 500 mL 500 mL, intravenous, at 10 mL/hr, Once Carrier Fluid	_____	_____

Provider Signature: _____ Date: _____ Time: _____

* May be used as EPIC Downtime Form

Place Patient Label
Inside This Box

Medications	Interval	Duration
☐ Ferric carboxymaltose (INJECTAFER) 750 mg in sodium chloride 0.9 % 100 mL IVPB 750 mg, intravenous, for 15 Minutes, DO NOT MIX WITH OTHER MEDICATIONS OR IV FLUIDS MAY REPEAT DOSE AFTER 7 DAYS	_____	_____
Infusion Reaction Management		
☐ DiphenhydrAMINE (BENADRYL) injection 50 mg 50 mg, intravenous, Once as needed, itching, For 1 Dose	_____	_____
☐ methylPREDNISolone sodium succinate (Solu-MEDROL) injection 100 mg 100 mg, intravenous, Once as needed, for upper airway swelling, For 1 Dose	_____	_____
☐ Albuterol nebulizer solution 2.5 mg 2.5 mg, nebulization, Every 2 hour PRN, wheezing	_____	_____
☐ EPINEPHrine (ADRENALIN) injection 0.3 mg 0.3 mg, subcutaneous, Once as needed, anaphylaxis, For 1 Dose	_____	_____
☐ Sodium chloride 0.9 % infusion 500 mL/hr, intravenous, for 1 Hours, Once as needed, for SBP < 90 For 1 Hours	_____	_____
☐ Nursing oxygen orders / instructions Once O2 at 2 liters per minute via nasal cannula to maintain sats > 93%	_____	_____
Nursing Communication		
☐ Stop Infusion and call Physician if adverse reaction occurs	_____	_____

For Scheduling Fax Forms to: (910) 715-1177.

Provider Signature: _____ Date: _____ Time: _____

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