PARAGON HEALTHCARE

A Carelon Company

IRON INFUSION ORDERS

P: 877.365.5566 | **F:** 855.889.2946

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Patient Weight: _____ lbs. (required) Allergies: _____

Primary ICD-10: _____

****Medicare will not cover ICD-10 D50.9****

☐ Iron Deficiency Anemia

☐ Iron Deficiency Anemia s/t inadequate Dietary Iron Intake

☐ Other medical necessity: _____

Secondary ICD-10: _____ **(Medicare required)**

☐ End-stage Renal Disease ☐ Intestinal Malabsorption

☐ Chronic Kidney Disease ☐ Iron Deficiency in heart failure

☐ Adverse effect of other drug (oral iron intolerance or not adequate)

☐ Other medical necessity: _____

VENOFER THERAPY ORDER

☐ Venofer 200mg IV - Administer 5 doses over a 14 day period

☐ Venofer 200mg IV weekly x 5 weeks

☐ Other: _____

INJECTAFER THERAPY ORDER

****If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first or have a letter of medical necessity****

☐ **Patient weighing less than 50kg (110 lbs.)**
Dose: Injectafer 15mg/kg IV
Sig: Give 2 doses at least 7 days apart not to exceed 1500mg

☐ **Patient weighing 50kg (110 lbs.) or greater**
Dose: Injectafer 750mg IV
Sig: Give 2 doses at least 7 days apart not to exceed 1500mg

☐ **Heart failure dosing (standard) - please indicate initial dose and maintenance dose (if applicable)**

Day 1 dose: ☐ 500mg ☐ 1000mg

Week 6 dose: ☐ 500mg ☐ 1000mg

☐ Administer a maintenance dose of 500mg at week 12, 24 and 36 if ferritin <100 ng/mL or ferritin 100-300 ng/mL with transferrin sat <20%

**Serum ferritin and transferrin required prior to each maintenance dose

☐ **Heart failure dosing (other, specify):** _____

MONOFERRIC THERAPY ORDER

****If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first or have a letter of medical necessity****

☐ **Patient weighing less than 50kg (110 lbs.)**
Dose: Monoferric 20mg/kg IV x 1 dose

☐ **Patient weighing 50kg (110 lbs.) or greater**
Dose: Monoferric 1000mg IV x 1 dose

Other orders: _____

Lab orders: _____ **Frequency:** _____ Required labs to be drawn by: ☐ Paragon ☐ Referral Source

☐ Serum ferritin & transferrin at 12, 24, & 36 weeks (Injectafer in heart failure)

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen® 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x 1
  - 15-30kg (33-66lbs): EpiPen® 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x 1
- Solu-Medrol 125mg IV as needed (adult), refer to provider orders or policy for pediatric dosing
- NS 250-500 mL IV bolus as needed (adult), refer to provider orders or policy for pediatric bolus

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Paragon selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____

View our locations here:

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COMPREHENSIVE SUPPORT FOR IRON THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes (H&P) to support primary diagnosis
  - ☐ Does the patient have an intolerance, contraindication, or documented tried and failed use of oral iron? ☐Yes ☐No
  - ☐ Does the patient have an intolerance or documented tried and failed use of an IV iron product? ☐Yes ☐No If yes, which drug(s)? _____
- ☐ Labs showing iron deficiency anemia attached
- ☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

- ☐ **Labs indicating iron deficiency anemia - please attach**

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance