



**Ferric Carboxymaltose (Injectafer)**

**Patient and Physician Information**

Patient Name:	Date of Birth:	Patient Phone Number:
Physician Name:	Office Phone Number:	Fax Number:
Insurance:	Group Number:	Policy Number:
Hospitalization Status:	Patient Weight (kg):	Height (inches):
<input checked="" type="checkbox"/> Outpatient to Outpatient Infusion Center		
Allergies:		

\*\*\*Send patient demographics/insurance, clinical notes, and test results with orders\*\*\*

**Diagnosis Code/Description for treatment:** \_\_\_\_\_

**Orders**

Initiate IV Vascular Access Flush Orders #0643 for: ☐ Peripheral Line ☐ Midline ☐ PICC ☐ Port  
☒ Normal Saline 0.9% Solution 20 milliliter/hour INTRAVENOUS (J7050 : 250 ML = 1 unit)

\*\*Two doses of Injectafer generally result in a rise of Hemoglobin by 1 GM. **May repeat cycle in 30 days with a NEW order.**\*\*

☒ Ferric Carboxymaltose (Injectafer) 750 MG in 100 mL of 0.9% Normal Saline INTRAVENOUS ONCE over 20 minutes. Follow with a second dose 8 days AFTER initial dose. (J1439 : 1 MG = 1 unit)

**Infusion Reaction**

☒ If infusion reaction occurs, stop the infusion IMMEDIATELY, notify physician with details of reaction AND initiate the Outpatient Infusion HYPERsensitivity, OIC orders #1024

**Discharge**

☒ Discharge home 30 minutes after treatment complete if stable.

**Date and Physician Signature**

DATE: \_\_\_\_\_  
10232512

TIME: \_\_\_\_\_

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE