Clearwater: Phone: 727.977.9717 I Fax: 727.977.9717
Tampa: Phone: 813.775.9997 I Fax: 813.775.9997
Email: intake@sageinfusion.com I Online: www.sageinfusion.com

Injectafer for CHF Orders

Patient Name: DOB: ☐ Male ☐ Female

Diagnosis (please provide ICD10 code)

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable):

☐ NKDA Allergies:

Ordering Provider:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

PRE-MEDICATION

☐ Acetaminophen1000mg PO
☐ Diphenhydramine25mg PO
☐ Ceterizine 10mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP

REQUIRED TESTING/LABS

☑ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached
☑ Most recent Hgb

INJECTAFER ORDERS Please circle appropriate weight and dosage

	Weight less than 70 kg			Weight 70 kg or more		
	Hb (g/dL)			Hb (g/dL)		
	< 10	10 to 14	> 14 to <15	< 10	10 to 14	> 14 to < 15
☐ **Day 1**	1,000 mg	1,000 mg	500 mg	1,000 mg	1,000 mg	500 mg
☐ **Week 6**	500 mg	No dose	No dose	1,000 mg	500 mg	No dose

Sage Infusion Standing Orders:

☑ Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

_____

Provider Name

_____ _____

Provider Signature Date