

# IV IRON ADULT PRESCRIBER ORDER FORM

Patient Name:		Date of Birth:	Gender:	
Address:			Patient Phone:	
Allergies: <input type="checkbox"/> NKDA OR (List):	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg
Insurance:	ID#	Emergency Contact:	Phone#:	
Primary Diagnosis Description:			ICD-10 Code:	

## Medication Orders

- Feraheme 510mg in 100mL 0.9% sodium chloride IV over 15 minutes every 3-8 days x 2 doses
- Feraheme 1.02 grams in 100mL 0.9% sodium chloride IV over 30 minutes x 1 dose
  
- Injectafer 750mg IV push undiluted over 7.5 minutes weekly x 2 doses
- Injectafer 15mg/kg (max 1g) IV in 250mL 0.9% sodium chloride x 1 dose over 15 minutes
  
- Venofer \_\_\_\_mg IV push undiluted over 5 minutes. Doses >200mg will be diluted in 250mL of 0.9% sodium chloride and administered over at least 15 minutes.  
Interval (must check one):
  - Once
  - Daily x \_\_\_\_doses
  - Every other day x \_\_\_\_doses
  - Every \_\_\_\_weeks x \_\_\_\_doses
- Other: \_\_\_\_\_
- Flush line with 2-3 ml 0.9% Sodium Chloride pre and post medication and/or Heparin 1-3 ml 10 units/mL as final flush.

Skilled Nursing to train patient/caregiver to self-administer medication, start peripheral line (where required), access/maintain central IV access (where applicable), monitor and treat ADR's and administer medications as ordered. RN to discontinue IV at completion of therapy. If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

## Ancillary Orders

### Anaphylaxis Kit

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

### Nursing Orders:

- If no central IV access, RN may insert peripheral IV, rotate site as needed.
- Weekly Lab Work:  CBC w/diff  CMP  CRP  ESR  Other: \_\_\_\_\_
- Other RN Orders: \_\_\_\_\_

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact:

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

**CONFIDENTIAL HEALTH INFORMATION:** Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. **IMPORTANT WARNING:** This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.

Not valid for use for patients residing in Arizona, New York, and Wisconsin