IV IRON ADULT PRESCRIBER ORDER FORM

Patient Name:		**Date of Birth:**		**Gender:**
Address:		**Patient Phone:**		
Allergies: ☐ NKDA OR (List):		**Height:**	☐ inches ☐ cm	**Weight:** ☐ lbs ☐ 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 and clinical documentation to: 713-983-4647

