

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							
<input type="checkbox"/> Feraheme 510mg in 100mL 0.9% sodium chloride IV over 15 minutes every 3-8 days x 2 doses <input type="checkbox"/> Feraheme 1.02 grams in 100mL 0.9% sodium chloride IV over 30 minutes x 1 dose <input type="checkbox"/> Injectafer 750mg IV push undiluted over 7.5 minutes weekly x 2 doses <input type="checkbox"/> Injectafer 15mg/kg (max 1g) IV in 250mL 0.9% sodium chloride x 1 dose over 15 minutes <input type="checkbox"/> 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): <input type="checkbox"/> Once <input type="checkbox"/> Daily x ____ doses <input type="checkbox"/> Every other day x ____ doses <input type="checkbox"/> Every ____ weeks x ____ doses <input type="checkbox"/> Other: _____ <input type="checkbox"/> 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 <input type="checkbox"/> 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. <input type="checkbox"/> Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement. <input type="checkbox"/> 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.							
Nursing Orders: <input type="checkbox"/> If no central IV access, RN may insert peripheral IV, rotate site as needed. <input type="checkbox"/> Weekly Lab Work: <input type="checkbox"/> CBC w/diff <input type="checkbox"/> CMP <input type="checkbox"/> CRP <input type="checkbox"/> ESR <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other RN Orders: _____							
<i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>							
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							
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