IV IRON ONLY PRESCRIBER ORDER FORM

Patient Name:		**Date of Birth:**		**Gender:**
Address:		**Patient Phone:**		
Allergies:		**Height:** ☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg
Insurance:	**ID#**	**Emergency Contact:**	**Phone#:**	
Primary Diagnosis Description:			**ICD-10 Code:**	

Medication Orders

- 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.
- Alteplase 2 mg IV to de-clot central IV access as needed for occlusion.
- Supplies for external drug infusion pump, per cassette or bag if needed.

☐ Feraheme 510mg IV Every 3-8 days x 2 doses

☐ Injectafer 750mg IV weekly x 2 doses

☐ Venofer 200mg IV every other day x 6 doses

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

