

ORDERING OFFICE, ALSO FAX:

- Most recent labs
- Supporting clinicals / Recent H&P
- Insurance card, front and back

Iron (Feraheme/Injectafer/Venofer)

Provider Order Form



Date:	Patient Name:	DOB:
ICD-10 code (required):		
ICD-10 description:		
<input type="checkbox"/> NKDA Allergies:		Weight lbs/kg:
Ordering Provider:		Provider NPI:
Referring Practice Name:		Phone: Fax:
Practice Address:		City: State: Zip Code:

NURSING

- Provide nursing care per IVX Standard Nursing Procedures, including reaction management and post-infusion observation

PRE-MEDICATION ORDERS (ADMINISTER 30 MINUTES PRIOR TO PROCEDURE)

- acetaminophen (Tylenol) 500mg / 650mg / 1000mg PO
 - cetirizine (Zyrtec) 10mg PO
 - loratadine (Claritin) 10mg PO
 - diphenhydramine (Benadryl) 25mg / 50mg PO / IV
 - methylprednisolone (Solu-Medrol) 40mg / 125mg IV
 - Other:
- Dose: Route: Frequency:

INFUSION THERAPY

- ferumoxytol (Feraheme) intravenous infusion
 - Dose & Frequency: initial 510mg infusion followed by a second 510mg infusion 3-8 days later
 - Dilute in 50 to 200ml 0.9% sodium chloride or 5% dextrose solution (final concentration 2mg to 8mg per ml)
 - Infuse over at least 15 minutes
 - No refills
- ferric carboxymaltose (Injectafer) intravenous infusion
 - Dose & Frequency: Patients >50kg: Two 750mg doses, 7 days apart / Patients <50kg: Two 15mg/kg doses, 7 days apart
 - Dilute in no more than 250ml 0.9% sodium chloride
 - Infuse over at least 15 minutes
 - No refills
- iron sucrose (Venofer) intravenous infusion
 - Dose: 100mg in 100ml 0.9% sodium chloride over at least 15 minutes
 - 200mg in 200ml 0.9% sodium chloride over 60 minutes
 - 300mg in 250ml 0.9% sodium chloride over 1.5 hours
 - 400mg in 250ml 0.9% sodium chloride over 2.5 hours
 - _____
 - Frequency: 5 doses over a 14 day period / every _____ days for _____ doses /
 - Refills: Zero / 12 months / _____
- Flush with 0.9% sodium chloride at the completion of infusion
- Patient is required to stay for 30-minute observation post infusion/injection

GENERAL PLAN COMMUNICATION

Special instructions/notes:

Ordering Provider: Initial here _____ and proceed to the next page.

ADULT REACTION MANAGEMENT

- Observe for **hypersensitivity reaction**: Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation
- If reaction occurs:
 - Stop infusion
 - Maintain/establish vascular access
 - Notify referring provider
 - Consider giving the following PRN
 1. Acetaminophen (Tylenol) 650mg PO **OR** _____mg for pain or fever > 38 C/100.4 F
 2. Diphenhydramine (Benadryl) 25-50mg in 10ml NS slow IV push for rash, itching, pruritis
 3. Ranitidine 25mg in 10ml NS slow IV push over 5 minutes (Consider if patient already given IV Benadryl)
 4. Ondansetron (Zofran) 4mg Slow IV push over 5 minutes for nausea or vomiting.
 5. Methylprednisolone (Solumedrol) 125mg **OR** _____mg slow IV push.
 6. Other _____
 - When symptoms resolve resume infusion at 50% previous rate and increase per manufacturer's guidelines
- Severe allergic/anaphylactic reaction**:
 - If symptoms are rapidly progressing or continuing after administration of prn medications above and signs symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension.)
 1. Call 911
 2. Consider giving epinephrine (1:1000 strength) 0.3ml IM. May repeat every 5-15 minutes to a maximum of 3 doses.
 3. Treat hypotension with 500ml 0.9% sodium chloride bolus. Repeat as needed to maintain systolic BP >90.
 4. Have oxygen by nasal canula available and administer 2-15 liters, titrate to keep Spo2 >92%
 5. Have Automated External Defibrillator available
 6. Notify referring provider. If unable to reach referring provider, notify Local Medical Director.
 7. Discontinue treatment

*Closely observe patients for signs and symptoms of hypersensitivity including monitoring of blood pressure and pulse during and after FeraHEME administration for at least 30 minutes and until clinically stable following completion of each infusion.

* Observe for signs and symptoms of hypersensitivity during and after Injectafer administration for at least 30 minutes and until clinically stable following completion of each administration.

*Monitor patients for signs and symptoms of hypersensitivity during and after Venofer administration for at least 30 minutes and until clinically stable following completion of the infusion.

Patient Name

Patient Date of Birth

Provider Name (Print)

Provider Signature

Date

Designate the desired location and fax the order form to:

CALIFORNIA fax: (844) 889-0275 | ___ San Mateo ___ Fremont ___ San Ramon ___ TBD

ILLINOIS fax: (312) 253-7244 | ___ Glenview ___ Schaumburg ___ TBD

KANSAS / MISSOURI fax: (844) 900-1292 | ___ Overland Park, KS ___ Lee's Summit, MO ___ Briarcliff, MO ___ TBD

OHIO fax: (844) 627-2675 | ___ Dublin ___ Pickerington ___ TBD

PENNSYLVANIA fax: (844) 820-9641 | ___ Malvern ___ Bensalem ___ Montgomeryville ___ East Shore ___ West Shore ___ TBD

TENNESSEE fax: (844) 627-2518 | ___ Brentwood ___ Hendersonville ___ TBD

