Health Care Medical
Infusion Specialties
An Access Infusion Care Company

IV IRON ORDERS

PATIENT INFORMATION

Patient Name: Test
Address: _____
City, State, Zip: _____
Cell: _____ Email _____
Height _____ Weight _____
Last 4 of SSN: _____ DOB: _____
Allergies: _____

PRESCRIBER INFORMATION

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

PRIMARY DIAGNOSIS

- ☐ D50.0 Iron Deficiency (Blood Loss Chronic)
- ☐ D50.1 Sideropenic Dysphagia
- ☐ D50.8 Other Iron Deficiency Anemia
- ☐ D63.0 Anemia in Neoplastic Disease (code neoplasm first)
- ☐ D63.1 Anemia in Chronic Kidney Disease (Code CKD Stage)
- ☐ D63.8 Anemia in Other Chronic Disease (Code Underlying Disease)
- ☐ D64.81 Antineoplastic Chemotherapy Induced Anemia
- ☐ ICD-10 CODE: _____

SECONDARY DIAGNOSIS (MUST SELECT ONE)

- ☐ K51.0 – K51.919 Ulcerative Colitis
- ☐ K90.0 Celiac Disease
- ☐ K90.4 Malabsorption due to intolerance, not elsewhere classified
- ☐ K90.9 Intestinal malabsorption unspecified, KN18
- ☐ N92.0 Excessive and frequent menstruation with regular cycle
- ☐ N92.5 Other unspecified irregular menstruation
- ☐ N92.6 Irregular menstruation, unspecified
- ☐ N18.1-N18.6. _____Stage Chronic Kidney Disease
- ☐ ICD-10 CODE: _____

REQUIRED DOCUMENTATION

- ☐ This signed order form by the provider
- ☐ Patient demographics AND insurance information
- ☐ CBC and Iron Panel (within 30 days)
- ☐ Documentation of failure of oral iron or iron intolerance
- ☐ Labs and tests supporting primary diagnosis

PRESCRIBING INFORMATION

Medication	Dose/Strength	Directions	Quantity
☐ Iron Sucrose (Venofer)	100 mg/5 mL	☐ Infuse 200 mg in 0.9% NS 100 mL IV over 30 minutes every 2 days x 5 doses	5 doses (10 vials)
		☐ Infuse 200 mg in 0.9% NS 100 mL IV over 30 minutes every 7 days x 5 doses	5 doses (10 vials)
☐ (Ferric Carboxymaltose) (Injectafer)	750 mg/ 15 mL	☐ Infuse 750 mg in 0.9% NS 250 mL IV over 30 minutes every 7 days x 2 doses	2 doses (2 vials)
		☐ If <50kg, infuse 15 mg/kg, (max dose 750 mg) in 0.9% NS 250 mL IV over 30 minutes every 7 days x 2 doses	2 doses (2 vials)
☐ Acetaminophen	650 mg	650 mg po prior to infusion	
☐ Diphenhydramine	25 mg	25 mg po prior to infusion	
NS 0.9% 10 mL		For PIV flush 3-10 mL NS before and after	
Heparin 10 units/mL		For PICC/Midline flush 10 mL NS before/after, then 3 mL Heparin 10 units/mL final flush	
Heparin 100 units/mL		For Port flush 10 mL NS before/after, then 5 mL Heparin 100 units/mL final flush	
NS 0.9% 50 mL bag		Flush residual priming volume post infusion	

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline
RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration
RN to flush and lock VAD/CVAD per company protocol
Other:_____

EMERGENCY MEDICATION

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults (>40 kg): Diphenhydramine 25–50 mg PO or IV slow push (2–5 min); Acetaminophen 325–650 mg PO; Methylprednisolone 125 mg IV slow push (≥5 min); Epinephrine 0.3 mg IM/SQ, may repeat ×1; 0.9% NS 500 mL IV over 30–60 min, may repeat ×1 for hypotension.
Pediatrics (<40 kg): Diphenhydramine 25 mg PO or IV slow push (2–5 min); Acetaminophen 325 mg PO; Methylprednisolone 40 mg IV slow push (≥5 min); Epinephrine 0.15 mg (<30 kg) or 0.3 mg (>30 kg) IM/SQ, may repeat ×1; 0.9% NS 500 mL IV over 30–60 min, may repeat ×1 for hypotension.
Oxygen (AIC/AIS only): 1–6 L/min via NC or face mask; titrate to maintain SpO_2 95–100%.

Prescriber Signature X: _____
Product Substitution Permitted: ☐ Date: _____

X: _____
Dispense as Written: ☐ Date: _____

Print, complete, and fax this form to: (769) 233-8051