



**St. Charles Health System**

Adult Ambulatory Infusion Order  
Iron Dextran (INFED)

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

*Patient Identification*

**ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK ( ✓ ) TO BE ACTIVE**

Treatment Start Date: \_\_\_\_\_ Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_ kg Height: \_\_\_\_\_ cm

**REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety**

- 1. FACE SHEET with complete INSURANCE information and patient CONTACT information**
- 2. Recent VISIT NOTE to support treatment (if not available in Epic)**
- 3. LAB RESULTS for any required prescreening (if not available in Epic)**
- 4. DIAGNOSIS CODE \_\_\_\_\_**
- 5. Patient NAME and DATE OF BIRTH on EVERY page faxed**

**GUIDELINES FOR ORDERING**

- 1. Send FACE SHEET and H&P or most recent chart note.**
2. If patient is pregnant, estimated due date is: \_\_\_\_\_.
3. Provider must order and obtain a ferritin prior to patient being scheduled for iron infusion.  
Labs drawn date: \_\_\_\_\_ Copy of ferritin must be attached.
4. Oral iron should be discontinued prior to administration of iron dextran.
5. Many insurance providers require a ferritin result within 90 days. If ferritin is not within 90 days of signed date then patient's insurance may deny coverage for this treatment.
6. Premedication is not required prior to infusion of iron dextran. If premedication is needed, such as in patients with multiple drug allergies, history of asthma, or history of reaction to iron products; consider premedication with methylprednisolone. For treatment of mild infusion reactions, consider treatment with methylprednisolone. Avoid use of diphenhydramine to be used as a premedication or treatment of mild reactions.
7. Serum transferrin saturation and ferritin should be re-assessed approximately 4 weeks after completion of iron infusion course.

**NURSING ORDERS:**

1. TREATMENT PARAMETER – Hold treatment and notify provider if ferritin greater than 300 ng/mL.
2. Monitor blood pressure prior to infusion, every 15 minutes during infusion, and 15 minutes after infusion x 2 (30-minute total post-infusion observation). Monitor for extravasation and stop infusion immediately if this occurs.
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

**MEDICATIONS:**

**Iron Dextran (Infed) 1000mg (test dose and infusion)**

Iron dextran (INFED) 25 mg over 15 minutes, followed by a 15-minute observation period, then if no reaction, remaining 975 mg in sodium chloride 0.9% 500 mL, intravenous, ONCE, over 1 hour.



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**AS NEEDED MEDICATIONS:**

1. May run sodium chloride 0.9% 500 mL as needed, x1 dose, to decrease vein discomfort.

**HYPERSENSITIVITY MEDICATIONS:**

NURSING COMMUNICATION – Avoid intravenous or oral diphenhydrAMINE, move to next option in the algorithm. Adverse effects of diphenhydrAMINE may overlap with IV iron adverse effects such as flushing, hypotension, tachycardia.

NURSING COMMUNICATION – Remember to watch for S/S of non-allergic or Fishbane reactions and to educate the patient that these are normal and should resolve quickly after stopping the infusion for 10-15 minutes (and typically do not recur after restarting the infusion). Common S/S are chest/back tightness, joint/muscle soreness, transient flushing, and dizziness. Typically, these symptoms are not accompanied by severe symptoms such as hypotension, wheezing, stridor, or laryngeal edema.

1. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
2. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
4. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
5. albuterol 2.5 mg/3 mL nebulize, AS NEEDED x1 dose for hypersensitivity reaction

Patient will be treated at the following infusion location:

- St. Charles Outpatient Infusion Center  
2500 NE Neff Road, Bend, OR 97701  
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

**ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION**

Signature: \_\_\_\_\_ License #: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_



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**Plan will expire 1 year after signature date at which time a new order will need to be placed**