St. Charles HEALTH SYSTEM	**St. Charles Health System** Adult Ambulatory Infusion Order Iron Sucrose (VENOFER)	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. 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.
5. 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 Sucrose (Venofer):

☐ 100 mg in sodium chloride 0.9% 100 mL, intravenous, over 30 min or IV push over at least 5 min (site discretion) x 5 doses over 14 days

☐ 200 mg in sodium chloride 0.9% 100 mL, intravenous, over 60 min or IV push over at least 5 min (site discretion) x 5 doses over 14 days

☐ 300 mg in sodium chloride 0.9% 250 mL, intravenous, over 1.5 hours x 3 doses (administered every 2 to 3 days)

☐ _____ mg in sodium chloride 0.9%, intravenous, over _____ (Pharmacy to prepare in an appropriate volume and may adjust the duration based on the dose ordered)

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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.

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 nebule, 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: _____

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