Premier Health Intravenous Iron Infusion Faxed Order Form

- **ALL Sections of this order form must be completed prior to scheduling in outpatient infusion center.**

Infusion Center Fax numbers:

MVH Middletown 513-974-5023
MVH South 937-641-2676
MVH North 937-641-2378
MVH Troy 937-440-4503
MVH Greenville 937-641-7205

Patient Name _____Date of Birth_____

Patient's Allergies _____

Patient's Actual Body Weight (in kg)_____Patient's Height_____ Date obtained_____

Patient's Insurance_____

Ordering Provider_____ Provider's Phone_____Fax #_____

PLEASE HAVE PATIENT BRING CURRENT MEDICATION LIST

Primary and secondary diagnosis (must select one from each column)	❑ Iron deficiency anemia secondary to blood loss (chronic)(D50.0) ❑ Iron deficiency anemia, unspecified (D50.9) ❑ Acute post hemorrhagic anemia (D62) ❑ Anemia in chronic kidney disease (D63.1) ❑ Anemia due to antineoplastic chemotherapy (D64.81) ❑ OTHER: _____ (Premier Prior Authorization team will do an evaluation to ensure the diagnosis code meets medical necessity requirements.)	❑ Intestinal malabsorption unspecified/failed oral iron (K90.) ❑ Chronic kidney disease, stage 1 (N18.1) ❑ Chronic kidney disease, stage 2 (N18.2) ❑ Chronic kidney disease, stage 3 (N18.3) ❑ Chronic kidney disease, stage 4 (N18.4) ❑ Excessive and frequent menstruation with regular cycle (N92.0) ❑ Irregular menstruation, unspecified (N92.6) ❑ OTHER:_____
For first doses	❑ Prior failed conventional therapies: _____	
For continuation of therapy	❑ Patient has positive clinical response to prior infusions and continuation of therapy is necessary.	

LABS: (must be completed within 4 weeks prior to appointment)

❑ Hgb result_____ ❑ Ferritin result _____ ❑ TSAT result _____

NURSING ORDERS:

- ❑ Vital signs at baseline, then 5 minutes after initiation, then every 30 minutes until completion
- ❑ Observe for hypersensitivity reactions during infusion- this includes hypotension, shortness of breath, and rash
- ❑ Check vitals immediately after completion, then 30 minutes post infusion. The patient must be observed for at least 30 minutes after completion of the iron infusion for hypersensitivity reactions.
- ❑ Discontinue IV and discharge patient upon completion of therapy.

PREMEDICATIONS: (check those preferred- only recommended for patients with multiple allergies or asthma)

- ❑ Acetaminophen 650mg PO once
- ☐ MethylPREDNISolone (SOLU-MEDROL) 125mg IVP once
- ❑ Miscellaneous
  - _____

LABS: (if needed)

❑ CBC ❑ Ferritin ❑ TSAT

Patient Name _____Date of Birth_____

INTRAVENOUS THERAPY:

- ❑ 0.9% NaCl 500mL, Intravenous CONTINOUS at 20ml/hr
- ❑ Saline flush IV push PRN – as needed

INTRAVENOUS IRON: (select drug and dose)

- ❑ **Ferric Derisomaltose (Monoferric) -Preferred PH agent**
  ___ Patient weight greater than or equal to 50kg – Ferric derisomaltose 1000mg IVPB once over 20 minutes
  ___ Patient weight less than 50kg – Ferric derismaltose 20mg/kg IVPB once over 20 minutes
- ❑ Ferric Carboxymaltose (Injectafer)
  ___ Patient weight greater than or equal to 50kg – Ferric carboxymaltose 750mg IVPB over 20 minutes every 7 days x 2 doses
  ___ Patient weight less than 50kg – Ferric carboxymaltose 15mg/kg IVPB over 20 minutes every 7 days x 2 doses
- ❑ Iron Sucrose (Venofer)
  ___ Iron sucrose 200mg IVPB every ___ days x 5 doses
  ___ Iron sucrose 300mg IVPB every ___ days x 3 doses
  ___ Iron sucrose ____ mg IVPB every ___ days x ___ doses
- ❑ Ferumoxytol (Feraheme)
  ____ Ferumoxytol 510mg in NaCl 0.9% 100ml IVPB over 15 minutes every 7 days x 2 doses
  ____ Ferumoxytol 1020mg in NaCl 0.9% 250ml IVPB over 30 minutes x 1 dose
- ❑ Iron Dextran (InFed)
  ___ Test Dose : Prior to first dose: Iron dextran (INFED) 25mg in NaCl 50ml IVPB once 10ml/min for 5 minutes. Wait an additional 60 minutes then give remaining dose.
  Therapeutic Dose: _____ 325 mg in NaCl 0.9% 100ml over 60 minutes daily x 3 doses
  _____ 475mg in NaCl 0.9% 250ml over 60 minutes daily x 2 doses
  _____ 975mg in NaCl 0.9% 250ml over 120 minutes x 1 dose

INFUSION REACTION PROTOCOL:

- ✓ Premier Health standard infusion reaction protocols

Provider signature_____Date/Time _____

Printed provider name_____