Outpatient Intravenous Iron Order Set

Klickitat Valley Health
Phone: 509-772-2695 Fax: 509-773-3354

General

Patient Name _____ DOB _____ Height _____ Weight _____ Phone #_____

Order Start Date _____ Order Expiration Date _____

Allergies: _____

Guidelines for Ordering:

1. Send **FACE SHEET** and **H&P** or most recent chart note.
2. Send pertinent **labs**, such as ferritin level, (must be within last 30 days).

DIAGNOSIS CODE: **IF using 'Other' must include ICD10 code**

☐ D50.9 Iron deficiency anemia ☐ D50.0 Iron deficiency anemia due to chronic blood loss

☐ D63.1 Anemia in chronic kidney disease ☐ Other: _____

Nursing Orders

☐ **IV ACCESS:** ☐ Place peripheral IV ☐ Access Implanted Port

If nurse to access implanted port please complete Port Access Order Set as well

☒ Vital Signs: baseline and every 30 minutes until discharge. Hold patient for 30 minutes post-infusion to observe/monitor for adverse reaction

Pre-Medications

☐ Acetaminophen (Tylenol) 650mg PO x1 dose ☐ Famotidine (Pepcid) 20mg IV x1 dose

☐ Diphenhydramine (Benadryl) 25mg PO x1 dose ☐ Methylprednisolone (Solu-medrol) 125mg IV x 1 dose

Medication Orders

Iron Sucrose (Venofer)

☐ Iron Sucrose 200mg in sodium chloride 0.9% 100mL IV over 2 hours every ___ days x ___ doses

☐ Iron Sucrose ____mg in sodium chloride 0.9% ____mL IV over ___ hours every ___ days x ___ doses

Ferric Carboxymaltose (Injectafer)

☐ Ferric Carboxymaltose 750mg in sodium chloride 0.9% 250 mL IV over 30min every 7 days x 2 doses

Ferumoxytol (Feraheme)

☐ Ferumoxytol 510 mg in sodium chloride 0.9% 100mL IV over 30min x 1 dose

☐ Ferumoxytol 510 mg in sodium chloride 0.9% 100mL IV over 30min every ___ days x ___ doses

MANAGEMENT OF SIDE EFFECTS

☒ If adverse reaction (Hypotensive Reaction of SBP drop 25mmHg, phlebitis/vein spasm, abdominal/leg cramps, nausea, diarrhea): Hold infusion x 30 mins, if symptoms improve resume infusion at half previous rate, if symptoms persist give 500ml IV sodium chloride 0.9% bolus and call provider. If afterhours call hospitalist.

IF ANAPHYLACTIC REACTION OCCURS

☒ Stop infusion immediately, notify hospitalist, administer oxygen prn, administer diphenhydramine 50 mg IV once STAT, administer epinephrine (1:1000) 0.5mg IV once STAT, possible admission to emergency department for further evaluation/treatment.

OUTPATIENT NURSE- PLACE STICKER HERE

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Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patent identified on this form.

I hold an active, unrestricted license to practice medicine in _____ *(specify state)*

My physician license number is # _____ and I am acting within my scope of practice and authorized by law to order infusion of the medication described above for the patient identified on this form.

Provider Signature: _____ **Date _____**

Printed name: _____ **Phone: _____** **Fax: _____**

KVH Provider Co-signature:

**Required for all external orders*

Provider Signature: _____ **Date _____**

Printed name: _____

OUTPATIENT NURSE- PLACE STICKER HERE