PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

Northern Light Health

☐ NL Infusion Care, AR Gould, **Presque Isle**
Phone: 207-768-4589; Fax: 207-768-4183
☐ NL Infusion Care, **Blue Hill**
Phone: 207-374-3995; Fax: 207-374-3970
☐ NL Infusion Care, CA Dean, **Greenville**
Phone: 207-695-5222; Fax: 207-695-4801
☐ NL Infusion Care, **Brewer**
Phone: 207-973-9785; Fax: 207-973-9788
☐ NL Infusion Care, **Waterville**
Phone: 207-861-3380; Fax: 207-861-3348
☐ NL Mary Dow Center, **Ellsworth**
Phone: 207-664-5584; Fax: 207-664-5485
☐ NL Infusion Care, Mayo, **Dover-Foxcroft**
Phone: 207-564-4254; Fax: 207-564-4418
☐ NL Mercy Cancer Care, **Portland**
Phone: 207-553-6868; Fax: 207-904-0917
☐ NL Infusion Care, SVH, **Pittsfield**
Phone: 207-487-4052; Fax: 207-487-3995

OP Iron Therapy (Paper)

Demographics:
Weight: _____ kg
Serum Creatinine: _____ mg/dL (Date: _____)
Hemoglobin: _____ g/dL (Date: _____)
Ferritin: _____ ng/mL (Date: _____)
Transferrin saturation: _____ % (Date: _____)

Diagnoses for Iron Therapy:

☐ Anemia in neoplastic disease [D63.0]
☐ CKD, Stage 3: (mod) GFR 30 to 59 [N18.32]
☐ CKD, Stage 4: (severe) GFR 15 to 29 [N18.4]
☐ CKD, Stage 5: GFR less than 15 [N18.5]
☐ Intestinal malabsorption, unspecified [K90.9]
☐ Other iron deficiency anemias [D50.8]
☐ Iron deficiency anemia secondary blood loss (chronic) [D50.0]
☐ Iron deficiency anemia, unspecified [D50.9]
☐ Personal hx of other diseases of the digestive system [Z87.19]
☐ Anemia complicating pregnancy - first trimester [O99.011]
☐ Anemia complicating pregnancy - second trimester [O99.012]
☐ Anemia complicating pregnancy - third trimester [O99.013]
☐ Adverse effect of iron and its compounds, initial encounter [T45.4X5A]

Iron dose required for repletion of iron & normal Hgb = [(Target Hgb 13 – Patient's Hgb) x 200 mg] + [(100 – Patient's ferritin) x 10]

☐ **Iron Sucrose (Venofer)** *200 mg, IV, every _____ **Days / Weeks / Months**, _____ Doses/Times*

☐ **Iron Sucrose (Venofer)** *_____ mg, IV, every _____ **Days / Weeks / Months**, _____ Doses/Times*

☐ **Ferumoxytol (Feraheme)**

- ☐ *510 mg, IVPB, ONCE, Administer IV over 20 minutes concurrently with 100 mL Sodium Chloride 0.9%, Record vital signs before and every 15 minutes x 2 after dose*
- ☐ *510 mg, IVPB, Weekly, 2 Doses/Times, Administer IV over 20 minutes concurrently with 100 mL Sodium Chloride 0.9%, Record vital signs before and every 15 minutes x 2 after dose*

☐ **Ferric Carboxymaltose (Injectafer)**

- ☐ *750 mg, IVP, ONCE, Administer IVP over 8 minutes, Record vital signs before and every 15 minutes x 2 after dose*
- ☐ *750 mg, IVP, Weekly, 2 Doses/Times, Administer IVP over 8 minutes, Record vital signs before and every 15 minutes x 2 after dose*

☐ **Ferric derisomaltose (Monoferric)**

- ☐ *Weights greater than or equal to 50 kg, 1000 mg, IVPB, ONCE, Administer over 20 minutes, Monitor for hypersensitivity for 30 min post infusion*
- ☐ *Weights less than 50 kg, 20 mg/kg = _____ mg, IVPB, ONCE, Administer over 20 minutes, Monitor for hypersensitivity for 30 min post infusion*

Administer Iron Dextran Test Dose with the initial treatment. Pharmacy will determine if test dose is needed if not ordered. Subsequent treatments do not require a test dose if no previous reaction noted.

☐ Iron Dextran (InFeD) Test Dose not required for this treatment.

PROVIDERS: Order Acetaminophen WITH Iron Dextran (InFeD)

☐ **Acetaminophen (Tylenol)** *650 mg, Tab, PO, Pre-Procedure, 1 Dose/Time, Administer just prior to Iron Dextran*

☐ **Iron Dextran (InFeD)** *100 mg, IV, ONCE, **Test Dose***
(1) Administer IV over 15 minutes
(2) If patient is NOT experiencing dyspnea, hypotension, fever, or tachycardia, then continue with balance of dose

Date: _____ Time: _____
Provider Signature: _____ Print Name: _____
Phone: _____ Fax: _____
Pharmacy Signature: _____

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PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS

(3) Fishbane Reaction – self-limiting chest and/or back pain with no change in vital signs. Hold remaining dose and notify provider. Provider will determine whether to restart infusion.

☐ **Iron Dextran (InFeD)** _____ *mg, IV, ONCE, Round to nearest 100 mg,* ***Maximum dose = 1500 mg***

(1) Check patency and placement of IV prior to infusing
(2) Record vital signs prior to initiation. Monitor vital signs and IV patency after 30 mins and PRN
(3) Stop infusion for dyspnea, hypotension (greater than 20% decrease in systolic blood pressure), fever, tachycardia, bradycardia, chest pain, or staining of skin
(4) If anaphylaxis occurs: Stop the infusion, call Rapid Response Team, notify provider, and administer anaphylaxis medications per Anaphylaxis PowerPlan.

Adjunct Therapy

☐ Provider Communication *Instruct patient to take Gentle Iron 2 CAP, PO, Daily and Ascorbic Acid (Vitamin C) 500 mg, PO, Daily pre-op and for three months post-op*

☐ Provider Communication *Instruct patient to take Ascorbic Acid (Vitamin C) 500 mg, PO, Daily and Folic Acid 800 mcg, PO, Daily pre-op and for three months post-op*

☐ Provider Communication *Instruct patient to take Vitamin B Complex 1 Tab, PO, Daily with the equivalent of Vitamin C 500 mg, PO, Daily and Folic Acid 800 mcg, PO, Daily. This is equivalent to Nephrocaps. Patient to continue taking Nephrocaps if previously prescribed.*

☐ **Cyanocobalamin (Vitamin B12)** _____ *mg, Tab, SL, Daily*

Laboratory

☐ CBC without Differential *Routine, ONCE, Obtain in _____* ***Days / Weeks / Months***

☐ Iron Level *Routine, ONCE, Obtain in _____* ***Days / Weeks / Months***

At Next Visit:

☐ Iron Level *Routine, ONCE, Obtain at next visit in _____* ***Days / Weeks / Months***

☐ Iron Level and TIBC *Routine, ONCE, Obtain at next visit in _____* ***Days / Weeks / Months***

☐ Ferritin *Routine, ONCE, Obtain at next visit in _____* ***Days / Weeks / Months***

After Completion of Total Dose:

☐ Hemoglobin *Routine, ONCE, Obtain after completion of total dose in _____* ***Days / Weeks / Months***

☐ Iron Level *Routine, ONCE, Obtain after completion of total dose in _____* ***Days / Weeks / Months***

☐ Iron Level and TIBC *Routine, ONCE, Obtain after completion of total dose in _____* ***Days / Weeks / Months***

☐ Ferritin *Routine, ONCE, Obtain after completion of total dose in _____* ***Days / Weeks / Months***

**Safety & Efficacy of Rapidly Administered (one hour) One Gram of Low Molecular Weight Iron Dextran for the Treatment of Iron Deficient Anemia, Auerbach, M, et al, Am J Hematology, August 2011*

Date: _____ Time: _____

Provider Signature: _____ Print Name: _____

Phone: _____ Fax: _____

Pharmacy Signature: _____