Atrium Health Infusion Centers Rev: 5/2023

Phone: 704-468-3400 Fax: 704-468-3401

Iron Infusion Order

Instructions to Provider: All orders with ☒ will be placed unless otherwise noted. **Section 3 – Insurance preference will guide iron product given to patient. Therefore, MULTIPLE PRODUCTS should be selected – pick all that patient MAY receive.** Based on insurer authorization, only 1 iron product within provider selections will be verified and administered. Fax completed order, along with referral form to 704-468-3401.

Required Labs: CBC within the last 3 months. Must be completed prior to scheduling.

Section 1. ICD-10/Diagnosis: _____

Section 2. Pre-Medications – Select when to give pre-medications and what pre-medications should be given:

(*Consider pre-medications for patients with prior reactions to iron products or existing allergies*)

☐ No pre-medication needed.

☐ Give prior to Iron Dextran (INFED) **only**.

☐ Give prior to ANY IV iron preparation.

Select from the following options:

- ☐ acetaminophen (TYLENOL) 650mg PO x1
- ☐ diphenhydramine (BENADRYL) 50mg PO x 1
- ☐ diphenhydramine (BENADRYL) 25mg IV x 1
- ☐ methylprednisolone (SOLUMEDROL) 20 mg IV x 1

Section 3. Infusion Therapy (SELECT ALL IRON PRODUCTS THAT THE PATIENT MAY RECEIVE. Final product will be determined according to payor's approval):

Ferric Carboxymaltose (INJECTAFER) – Select 1 dosing option from below (MUST check 1 option).

- ☐ 750mg IV weekly x 2 doses
- ☐ 750mg IV ONCE
- ☐ 15mg/kg (<50 kg) IV weekly x 2 doses
- ☐ 15mg/kg (<50 kg) IV ONCE
- ☐ Do Not Auth (reason required): ☐ Intolerance ☐ Inadequate Response ☐ Other: _____

Ferumoxytol (FERAHEME) – Select 1 dosing option from below (MUST check 1 option).

- ☐ 510mg IV weekly x 2 doses
- ☐ 510mg IV ONCE
- ☐ Do Not Auth (reason required): ☐ Intolerance ☐ Inadequate Response ☐ Other: _____

Iron Sucrose (VENOFER) – Select 1 dosing option from below (MUST check 1 option).

- ☐ 200mg IV three times a week x 5 doses
- ☐ 300mg IV weekly x 2 doses followed by 400 mg IV weekly x1.
- ☐ Do Not Auth (reason required): ☐ Intolerance ☐ Inadequate Response ☐ Other: _____

Iron Dextran (INFED) – Select 1 dosing option from below (MUST check 1 option).

- ☐ 1000 mg IV once over (SELECT DURATION)
- ☐ _____mg **(**Calculated Iron Deficit)

*Total Dose Calculation: Dose (mL) = 0.442 (Desired Hgb) X LBW + (0.26 x LBW)

Dose (mg) = Dose (mL) x 50 mg/mL

LBW = Lean body weight (kg) – Males: 50 kg + (2.3 kg x each inch height over 5 ft)

Females: 45.5 kg + (2.3 kg x each inch height over 5 ft)

- ☐ Do Not Auth (reason required): ☐ Intolerance ☐ Inadequate Response ☐ Other: _____

Select infusion duration:

- ☐ 1 hour (may use for doses ≤ 1000mg; NOT to be used for doses > 1000mg)
- ☐ 4 hours

Select if Test Dose is Needed:

- ☐ No
- ☐ Yes – 25mg IV over 1 minute. Wait for one hour; if no reaction, infuse remaining dose over indicated duration.

Special Instructions:

- ☒ Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.
- ☒ Infusion Monitoring: Obtain vital signs pre- and post-infusion. Obtain vital signs PRN during infusion.

Physician Name: _____	Patient Name:
Physician Signature: _____	DOB:
Date: _____ (Order valid for 1 year)	MRN: