Atrium Health Infusion Centers
Phone: 704-468-3400 **Fax:** 704-468-3401

Venofer Infusion Order (Revised 7/20/21)

Instructions to Provider: All orders with ☒ will be placed unless otherwise noted. Please fax completed order, along with referral form.

Required Lab Results: CBC performed within 6 months prior to treatment. (If outside of Atrium, please fax with order. Required prior to scheduling.)

Infusion Therapy:

☐ Venofer (iron sucrose) **500mg** IV over 4 hours (non-dialysis dependent patients only)

Frequency: Day 1 and Day 14 (non-dialysis dependent patients only) **OR**

☐ Venofer (iron sucrose) _____mg (usually 200mg) IV over 60 minutes

Frequency: _____ (usually 5 doses, maximum of 3 doses per week)

ICD 10 code: _____

Pre-Meds: Administer 30 minutes prior to Venofer ☐ No Pre-meds Needed

☐Acetaminophen _____ mg PO x 1

☐Benadryl _____ mg PO or _____mg IV x 1 *(if applicable, only choose ONE)*

☐SoluMedrol_____ mg IV x 1

☐Famotidine _____mg IV x 1

PRN Medications:

☐Zofran **4**mg IV every 3 hours PRN nausea/vomiting

☐Ibuprofen **800**mg PO every 8 hours PRN pain

Additional Orders:

_____

_____

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.
- Monitor for signs of reaction for 30mins after completion of the infusion.

Provider Name: _____

Provider Signature: _____

Date: _____ (Order valid for 1 year)

Patient Name:

DOB:

MRN: