HONORHEALTH

IRON REPLACEMENT

(Venofer, Infed, Injectafer)

Order Form

Outpatient Infusion

Patient Name	
DOB	
Address	
Phone	

Order Status	☐ New Order	☐ Renewal	☐ Dose or Frequency Change
Allergies:		**Weight:** **Height:**	
Diagnosis	☐ Iron-deficiency anemia, treatment ☐ Other:	**Diagnosis Code:**	
Required Information	CBC, CMP, ferritin (please include lab result documents)	Date:	
Labs	☐ CBC, CMP every:	☐ Other:	

Required Documentation

- H&P or progress note supporting diagnosis
- Failed oral iron therapy
- Medication history
- Recent labs (as above) and/or diagnostic test results

Pre-Medications

☐ Acetaminophen PO ○ 325 mg ○ 650 mg

☐ Other:

Medication Order

☐ Iron Sucrose (Venofer)
- ○ _____ mg IV every _______________ for _____ doses

☐ Ferric Carboxymaltose (Injectafer)
- ○ _____ mg IV every _______________ for _____ doses

☐ Iron Dextran (Infed)
- ○ _____ mg IV every _______________ for _____ doses
  (Iron dextran test dose of 25 mg over 10 minutes, followed by 15-minute observation period and then remaining dose infused over 1 hour unless otherwise specified)

Infusion Reaction Medications

Hypersensitivity Reaction Protocol will be utilized unless otherwise specified

Provider (print name):	Date:
Provider Signature:	NPI:
Office Phone:	Office Fax: