Asante Outpatient Infusion - Iron Order Set

Patient Name: _____ DOB: _____

Height: _____ in cm Weight: _____ lbs kg Allergies: _____

ICD-10 Diagnosis Code (Please provide at least one):
D63.1 Anemia in chronic kidney disease (**CKD stage required** 3, 4, 5, or N18.9 CKD, unknown)
-OR- D50.9 Iron deficiency anemia -OR- _____

Vital Signs:
- Temp, heart rate, respiratory rate, and blood pressure at baseline and every ___ minutes (30 minutes if left blank)
- Notify provider if the following parameters are met: SBP greater than ___ or less than ___, DBP greater than ___ or less than ___, Temp greater than ___° C (Values will be as follows if left blank: SBP is greater than 180 mmHg or less than 80 mmHg, DBP is greater than 90 mmHg or less than 50 mmHg, Temperature greater than 38° C)

Pre-Medications: Avoid in most patients. Consider if history of multiple drug allergies, asthma, or inflammatory arthritis:
☐ methylprednisolone sodium succinate (SOLU-MEDROL) 125 mg IV once 30 minutes prior to each dose

Hypersensitivity, infusion reaction & anaphylaxis emergency medication treatment:
- Notify the provider if a hypersensitivity, infusion-related or an anaphylactic reaction occurs
- A nurse may implement the Asante Hypersensitivity & Infusion Reaction Treatment Protocol in Adults (400-MEDS-0052)
- A copy of the protocol document will be provided upon request
- On-site provider where the patient is being treated will respond to reaction

Iron Product (Please select ONE of the following medications and fill in any applicable blanks):

PREFERRED PRODUCT: For indications including treatment of iron-deficiency anemia (IDA) in adults with an intolerance or unsatisfactory response to oral iron or who have chronic kidney disease (CKD):

☐ **Ferumoxytol (FERAHEME) IV infusion over 30 minutes with no test dose:**
Dose: 510 mg **Frequency:** weekly x 2 doses _____

For indications including treatment of IDA in adults with intolerance to oral iron or unsatisfactory response to oral iron or treatment of IDA in adults with nondialysis-dependent chronic kidney disease (ND-CKD):

☐ **Ferric carboxymaltose (INJECTAFER) IV Push over 30 minutes with no test dose:**
Dose: 750 mg for patients > 50 kg or 15 mg/kg for patients <50 kg **Frequency:** weekly x 2 doses

For indications including treatment of IDA in CKD:

☐ **Iron sucrose (VENOFER) IV infusion over 30 minutes with no test dose:**
Dose: 200 mg **Frequency:** X 5 doses over two weeks _____

LIMITED USE - For only iron-deficiency anemia, hemodialysis patients:

☐ **Ferric gluconate (FERRLECIT) IV infusion over 1 hour with no test dose:**
Dose: 125 mg **Frequency:** weekly for ___ weeks (generally 8 weeks)

LIMITED USE - Due to delayed reactions. Total dose infusions are not permitted for outpatients. For indications of treatment of iron deficiency in patients in whom oral administration is unsatisfactory or infeasible. **Test dose:** 25 mg IV iron dextran over 5 minutes via syringe followed by a one-hour observation period. If there is no reaction, continue with the remainder of dose. Repeat test dose if more than six months have elapsed since last iron dextran infusion.

☐ **Iron dextran (INFED) IV infusion over 1 hour with test dose during first infusion due to risk for reactions:**
Dose: 100 mg **Frequency:** weekly for ___ weeks

Attach the following to this order:
- Face sheet/Updated demographics
- H&P or recent progress note **with reason for parenteral iron listed in addition to previous treatment failures**
- Initial or recent lab work within last 30 days collected by provider including CBC, TIBC, and Ferritin

By signing below, the clinician is attesting the medical necessity to provide parenteral iron therapy.

Provider Name (Printed)	Provider Signature	Date	Time

Statement of Responsibility of Parties: Referring Healthcare Professional agrees that in referring such patients to Asante, the responsibility for the overall care of the patients referred related to the outpatient IV infusion services, as well as the use of any 340B drugs transferred to an individual patient, remains with Asante.

ASANTE

Fax to: **Heimann Infusion 541-789-5678**
Spears Infusion 541-507-2601