Palmetto Infusion Services

MRN:_____

Phone: 800-809-1265 DOB: _____

Standard Plan of Treatment for Iron

(Re)Certification Period from _____ to _____

Note: We may require MD office notes and may require a letter of Medical Necessity (depending on diagnosis), to be able to verify eligibility and payment for this treatment through patients Medicare and/or other insurance plan.

Patient's Name _____ HT: _____ Weight: _____ Allergies: _____

Primary Diagnosis:

☐ Primary: _____ ☐ Secondary: _____

Orders:

Obtain weight each visit. Vital Signs every 30 minutes beginning with start of infusion, and 30 minutes post infusion then may discharge patient. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient response to therapy. Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn. Normal Saline Flush 3-10 ml before infusion, after primary drug has infused, Infuse Normal Saline 0.9% or D5W 20-50 ml to flush tubing/line, followed by Heparin Lock 1-5ml 100 units/ml as needed per line type. Pump, tubing, and supplies needed to complete prescribed therapy.

If adverse drug reaction, Implement the Standing Adverse Reaction protocol.

Infusion will be discontinued upon any sign/symptom of possible drug reaction

Dose:

☐ Iron Sucrose (**Venofer**): _____ mg in _____ ml 0.9% Normal Saline over ____ hour(s) via pump, every _____ weeks

☐ Iron Dextran (**Infed**) Total Dose: _____ mg

Test dose of 25mg/50ml NS IV over 15 minutes at pharmacist discretion

If no reaction after 30-60 minutes, then give remainder over ____ hour(s)

Continue Iron Dextran in 0.9% NS for ____ day(s), over _____ hour(s)

☐ Sodium Ferric Gluconate Complex (**Ferrlecit**): Total Dose: _____ mg

Test dose of 25mg/50ml NS IV over 15 minutes at pharmacist discretion

If no reaction in 30-60 minutes, then give remainder over _____ hour(s)

Administer _____ mg over _____ hour(s) every _____ day(s)

☐ Other: _____

Other:

Pharmacist to perform clinical drug monitoring

(No Stamped Signatures Please)

Physicians Signature: _____ _____ Date: _____

(Dispense as written) (Substitution Permitted)

Print Physician Name: _____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO 866-872-8920