RED RIVER HEALTH
Ambulatory Infusion Clinic

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IRON REPLACEMENT Infusion Orders

Patient Name: _____ DOB: _____ ☐ M ☐ F

☐ NKDA Allergies: _____

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider: _____ Provider NPI: _____

Practice Phone: _____ Practice Fax: _____

Diagnosis *(please provide ICD-10 code)*: ☐ _____ Iron Deficiency Anemia

☐ _____ Chronic Kidney Disease ☐ _____ _____

Please choose one & provide documentation: ☐ Oral Iron Intolerance ☐ Lack of Response to Oral Iron

Pre-Medication:

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ Other: _____

Required Documents:

☑ Patient Demographic Sheet
☑ Clinical/Progress Notes supporting primary diagnosis *(please attach)*
☑ Recent labs: CBC, Ferritin & Iron Studies *(within last 30 days)*

FERRLECIT ORDERS:

Dosing:
☐ 125 mg in 100 ml 0.9% sodium chloride over 60 minutes
☐ Other: _____

Frequency:
☐ every 1 week for _____ doses
☐ every _____ days for _____ doses

VENOFER ORDERS:

Dosing:
☐ 100 mg in 100 ml 0.9% sodium chloride over 30 minutes
☐ 200 mg in 100 ml 0.9% sodium chloride over 30 minutes
☐ 300 mg in 250 ml 0.9% sodium chloride over 90 minutes
☐ Other: _____

Frequency:
☐ every 1 week for 3 doses
☐ every _____ days for _____ doses

Red River Health Standing Orders:

☑ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: _____ Date: _____