LOWER UMPQUA HOSPITAL
OUTPATIENT NURSING DEPARTMENT
600 Ranch Road, Reedsport, OR 97467
Phone: (541) 271-2163 | **Fax:** (541) 271-4058

INTRAVENOUS IRON REPLACEMENT

Patient Name _____ **DOB** _____

Patient Phone # _____ **Patient Weight (Kg)** _____ **Patient Height (cm):** _____

Patient Allergies _____

Provider _____ **NPI#** _____

ICD-10 Code (REQUIRED) _____ **J Code** _____

Primary Diagnosis _____

Secondary Diagnosis _____

Duration (or # of treatments): _____ **Anticipated Infusion Date** _____

INSTRUCTIONS TO PROVIDER:

- ***Allow 2 business days*** *for request to be processed. For* ***URGENT requests****, call Outpatient Nursing x5205.*
- ***Please ensure insurance authorization has been initiated PRIOR to signing orders.***
- *Lab orders should NOT be included on this form – place orders via usual method.* ***Lab monitoring is the responsibility of the ordering Provider.***
- *This plan will expire* ***after 365 days****, at which time new orders will need to be placed.*

MEDICATIONS:
{Choose ONE}
PREFERRED Regimens:

☐ **ferumoxytol** *(FERAHEME)* 510 mg in **0.9%sodium chloride** IV, over 15 minutes **x** 1; followed by a second dose **ferumoxytol** *(FERAHEME)* 510 mg in **0.9%sodium chloride** IV one week later.

- *NOTE: administration may alter MRI studies and alterations may persist up to 3 months.*

☐ **ferumoxytol** *(FERAHEME)* 1020 mg in **0.9 % sodium chloride** IV over 30 minutes **x** 1

- *NOTE: administration may alter MRI studies and alterations may persist up to 3 months.*

ALTERNATIVE Regimen:

☐ **ferric gluconate** *(FERRLECIT)* 125 mg in **0.9% sodium chloride** IV over 60 minutes

- Every #_____ days for #_____ treatments

**Commonly dosed once weekly for 6 to 8 doses per treatment course.*

OTHER: _____

_____

ORDERING GUIDELINES:

☒ Send **FACE SHEET and H&P or most recent chart note**

☒ Obtain hemoglobin, serum ferritin, serum iron, and transferrin saturation prior to initiation of therapy (within 90 days). Oral iron should be discontinued prior to administration of IV iron. Serum transferrin saturation and ferritin should be re-assessed approximately 4 weeks after completion of iron infusion course.

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Date _____ Time _____ Provider Signature _____

"Statement of Responsibility of Parties: referring Prescriber agrees that in referring patients to Lower Umpqua Hospital Outpatient Nursing Department, the responsibility for the care related to these Outpatient Nursing Therapy Plan orders, as well as administration of any 340B drugs, remains with Lower Umpqua Hospital."

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PRE-MEDICATIONS:

☐ Premedication should be avoided unless there is a history of hypersensitivity. In patients with multiple drug allergies, history of asthma, or history of reaction to iron products, consider pre-medication with **methylprednisolone** 125 mg.
☐ **acetaminophen** *(TYLENOL)* 650 mg PO **x** 1 dose – Give 30 to 60 minutes prior to infusion.
☐ **methylPREDNISolone sodium succinate** *(SOLU-Medrol)* 125 mg IV **x** 1 dose- Give 30 minutes prior to infusion.

TREATMENT PARAMETERS:

☒ Ferritin must be obtained within 90 days prior to start of treatment. HOLD INFUSION and NOTIFY PROVIDER if Ferritin is **greater than** 300 and transferrin saturation (TSAT) is **greater than** 20%

NURSING ORDERS:

☒ Patient should be in a reclined or semi-reclined position during the infusion. Monitor the patient and check vitals (including Blood Pressure and Heart Rate) for at least 30 minutes after infusion.
☒ Nurse to remind patient to contact Provider to set up lab tests approximately 4 weeks after completion of the treatment infusion.

HYDRATION / MAINTENANCE TKO:

☒ **0.9% sodium chloride** infusion 25 mL/hour IV once PRN per facility policy - flush/hydration/main bag/TKO

LINE CARE MAINTENANCE:

☒ Follow facility policies and procedures for all vascular access maintenance with appropriate flush solutions, de-clotting (**alteplase**), and/or dressing changes.
☒ **alteplase** *(CATHFLO ACTIVASE)* injection 2 mg/2 mL, intra-catheter **x** 1 PRN de-clotting per facility policy for 2 doses
☒ **heparin, porcine (Preservative Free)** 100 units/mL IV syringe, 500 units, intra-catheter **x** 1 PRN line care
☒ **0.9% sodium chloride** flush, 10 to 30 mL IV; See facility policy and/or medication admin instructions, flush as needed
☒ If applicable, may remove PICC line at the completion of course of therapy

EMERGENCY MEDICATIONS FOR HYPERSENSITIVITY / INFUSION REACTION:

** *Itching, hives, fever* **

☒ **STOP MEDICATION INFUSION if allergic reaction occurs**
☒ Establish IV access and infuse **0.9% sodium chloride** 500 mL at 25 mL/hour PRN Hypersensitivity / Allergic reaction
☒ VS Q15 minutes **x** 4 and PRN
☒ **acetaminophen** *(TYLENOL)* 650 mg PO Q4 hours PRN Hypersensitivity / Allergic Reaction
☒ **diphenhydramine** *(BENADRYL)* 25 mg IVP PRN Hypersensitivity / Allergic Reaction **x** 1 dose
May repeat **x** 1 ***{Maximum dose = 50 mg}***
☒ **NOTIFY** Provider of Hypersensitivity / Allergic Reaction
☒ **hydrocortisone** 100 mg IVP PRN Hypersensitivity / Allergic Reactions **x** 1 dose if reaction continues and is not relieved by maximum dose of **diphenhydramine**

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Date _____ Time _____ Provider Signature _____

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ANAPHYLAXIS REACTION

******* Wheezing, Dyspnea, Hypotension, Angioedema, Chest pain, Tongue swelling *****

- ☒ Transfer to Emergency Department (ED) as needed, and **NOTIFY** Provider
- ☒ **epinephrine** 0.3 mg IM PRN anaphylaxis **x** 1 dose

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