



Conveniently Located in East Syracuse, Onondaga Hill & Auburn

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**Intravenous Iron Non-Oncology Treatment Order Set**

1. Patient Name: \_\_\_\_\_

2. DOB: \_\_\_\_\_ Height (inches): \_\_\_\_\_ Weight (lbs): \_\_\_\_\_

**3. Diagnosis:**

Primary ICD-10 Code: \_\_\_\_\_ Diagnosis description: \_\_\_\_\_

Other ICD-10 Code: \_\_\_\_\_ Diagnosis description: \_\_\_\_\_

**4. Pre-medications:**

Acetaminophen:

1000mg PO  500mg PO

Diphenhydramine:

25mg PO  50mg PO  25mg IV  50mg IV

Hydrocortisone: 100mg IVP

Other Pre-medication: \_\_\_\_\_

No Pre-medications indicated

**5. Drug Order:**

**Injectafer (ferric carboxymaltose)**

Dose/Frequency: \_\_\_\_\_

**Feraheme (ferumoxytol)**

Dose/Frequency: \_\_\_\_\_

**Venofer (iron sucrose)**

Dose/Frequency: \_\_\_\_\_

**Other:** \_\_\_\_\_

*HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral*

**6. Infusion Lab Requirements:**

Other: \_\_\_\_\_

No lab monitoring indicated

*HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.*

*The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.*

**7. Required Baseline Lab/Testing completed:**

CBC, date: \_\_\_\_\_  CMP, date: \_\_\_\_\_  Other: \_\_\_\_\_

Iron studies, date: \_\_\_\_\_  Ferritin, date: \_\_\_\_\_

**8. Patient Assistance & REMS Program Enrollment**

Yes, patient has been enrolled in \_\_\_\_\_ program. (Provide Copy Enrollment Forms)

No, patient has not been enrolled in any programs.

7. Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(This drug administration order form is valid for 12 months)*