NEWLAND MEDICAL ASSOCIATES, P.C.

IV IRON ORDER FORM

Patient Information:

Name: _____ Date of Birth_____

Allergies: _____ Height: _____ Weight: _____

Diagnosis: _____ ICD 10: _____

Medication	Dose and Administration Instructions	# Doses
☐ Sodium ferric gluconate (Ferrlecit®)	☒ Infuse sodium chloride 0.9% 250 mL intravenously at 50 mL/hour to maintain IV line and flush IV line after infusion ☒ Infuse sodium ferric gluconate 125 mg in sodium chloride 0.9% 100 mL intravenously over 1 hour Frequency: ☐ Daily ☐ Weekly ☐ Twice weekly ☐	☐ ____
☐ Iron dextran (Infed®)	☒ Infuse sodium chloride 0.9% 250 mL intravenously at 50 mL/hour to maintain IV line and flush IV line after infusion ☐ Hydrocortisone 100 mg in sodium chloride 0.9% 25 mL intravenously over 15 min or by IV push (DAIC only) 30 minutes prior to iron dextran infusion (or test dose if test dose ordered) ☒ Test dose: Required for first dose and patients without a documented iron dextran dose within the past 6 months. Infuse iron dextran 25 mg in sodium chloride 0.9% 50 mL intravenously over 20 minutes. If no reaction after 30 minutes, infuse the remainder of the ordered dose. ☒ Infuse **Iron dextran _____ mg (minus 25 mg if test dose received same day)**(max dose 1500mg) in sodium chloride 0.9% 250 mL over 2 hours every _____ weeks	☐ ____
☐ Iron Sucrose (Venofer®)	☒ Infuse sodium chloride 0.9% 250 mL intravenously at 50 mL/hour to maintain IV line and flush IV line after infusion ☒ Infuse iron sucrose intravenously every _____ week(s) Dose: ☐ 100 mg in sodium chloride 0.9% 100 mL over 15 minutes ☐ 200 mg in sodium chloride 0.9% 100 mL over 15 minutes ☐ 300 mg in sodium chloride 0.9% 250 mL over 1.5 hours ☐ 400 mg in sodium chloride 0.9% 250 mL over 2 hours	☐ ____

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☐ Ferric Carboxymaltose (Injectafer®)	☒ Infuse sodium chloride 0.9% 250 mL intravenously at 50 mL/hour to maintain IV line and flush IV line after infusion ☒ Infuse ferric carboxymaltose in sodium chloride 0.9% 100 mL intravenously over 15 minutes on day 1 and 8 Dose: ☐ Weight less than 50kg: 15 mg/kg= _____ mg (maximum 750 mg/dose) ☐ Weight greater than or equal to 50 kg: 750 mg	☐ _____

Prescriber Information:

Name: _____ Date/ Time:_____

Phone: _____ Fax: _____

Signature: _____

****PLEASE SEND DEMOGPAHICS SHEET, INSURANCE CARDS, LAST OFFICE NOTE, AND LABS. A CBC AND IRON STUDIES WITHIN 4 WEEKS ARE REQUIRED****

RETURN FAX: 248-594-6747