

# Iron Infusion

## Patient Information

Full Name: \_\_\_\_\_ Weight: \_\_\_\_\_  lbs  kg Height: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Allergies:  NKDA \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Patient Status:  New to therapy  Continuing therapy Last Treatment Date: \_\_\_\_\_ Next Treatment Date: \_\_\_\_\_

## Required Documentation

- Patient Demographics and Insurance Card  Medication List  
 Clinical/Progress Notes Supporting Dx  Recent labs indicating iron deficiency anemia (Iron studies and CBC)

## Primary Diagnosis

 ICD-10 Code (required): \_\_\_\_\_  
 Iron Deficiency Anemia  Other: \_\_\_\_\_

## Pre-Medication

Per violet health protocol: No standard recommended pre-medications for VENOFEER, FERAHEME, OR INJECTAFER   Other: \_\_\_\_\_

## Therapy Administration

### Feraheme:

- Initial dose of Feraheme 510 mg IV followed by a second dose of Feraheme 510 mg IV 3-8 days later  
 Other: \_\_\_\_\_


### Injectafer:

- Injectafer 750 mg IV weekly for 2 doses  
 Injectafer 15 mg/kg IV weekly for 2 doses  
 Other: \_\_\_\_\_

### Venofer:

- Venofer 200 mg IV diluted in 100 ml of 0.9% NaCl administered on 5 different occasions over a 14 day period  
 Venofer 200 mg IV diluted in 100 ml of 0.9% NaCl administered weekly x 5 weeks  
 Other: \_\_\_\_\_

### Refills:

x 1 year  Other: \_\_\_\_\_  Order valid for one year unless otherwise stated

## Nursing Orders

- RN to flush and lock VAD/CVAD per violet health protocol (see violetinfusions.com/protocol for policy)  RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration.  
 Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy)  Other: Please fax alternative reaction orders, flush orders, or nursing administration orders if checking this box  
 RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines.

## Lab Orders

### Labs to be drawn:

- CBC  
 Ferritin, serum  
 Iron Panel  
 Other: \_\_\_\_\_

### Timing of Lab Draws:

- Pre- Treatment  
 1 week after therapy completion  
 \_\_\_\_\_ weeks after therapy completion

## Provider Information

Provider Name: \_\_\_\_\_ Office Contact Person: \_\_\_\_\_  
 Referring Practice Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Referring Practice Address: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
 Provider NPI: \_\_\_\_\_  
 Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_