Holland Hospital

AMBULATORY TREATMENT UNIT

Ambulatory Treatment Unit
Phone (616) 394-3547
Fax (616) 394-2139

IV Iron Infusion Order Set

☐ = Optional Order ● = Routine Order (Cross out and initial **BULLETED ORDERS** that do not apply)

ORDERS

Date: _____ **Time:** _____

Patient Name: _____ **Date of Birth:** _____ **Weight:** _____ (kg)

Allergies: _____

Diagnosis Code: (ICD-10) _____
Diagnosis:

Labs to be drawn 4 weeks post infusion:
☐ CBC
☐ Iron Studies
☐ Other: _____

MEDICATIONS

☐ **Venofer IV (Iron Sucrose)**
- ☐ 100mg *(Infusion over at least 15 minutes)*
- ☐ 200mg *(Infusion over at least 15 minutes)*
- ☐ 300mg

Number of doses _____ **Frequency** _____

Nursing Considerations
- Monitor for signs and symptoms of hypersensitivity and hypotension during infusion.

☐ **Injectafer IV (ferric carboxymaltose):**
- ☐ 500mg
- ☐ 750mg (recommended dose)
- ☐ 15mg/kg _____ (max 1000mg)
- ☐ 1000mg

Number of doses _____ **Frequency** _____

Nursing Considerations
- Monitor vital signs
- Monitor for signs and symptoms of hypersensitivity at least 30 minutes after infusion.
- Monitor infusion site for signs and symptoms of extravasation.

☑ **Methylprednisolone 40mg IV Push PRN (**Pre-infusion for patients with prior sensitivity)

Is patient on oral iron? ☐ Yes ☐ No **If Yes, is patient to discontinue?** ☐ Yes ☐ No

Treatment for Adverse Drug Reactions (*for mild to moderate infusion reaction*)
- Slow or stop infusion for 20 minutes
- Give:
  - Diphenhydramine (Benadryl) 25 mg slow IVP STAT (may repeat times 1)
  - Acetaminophen (Tylenol) 650 mg PO STAT, if not already given as a "premedication". *(Maximum acetaminophen doses of 4000 mg in 24 hours from all combined sources.)*
  - Methylprednisolone (Solu-Medrol) 125 mg IVP STAT
- Place O_2 PRN at 4 – 6 liters per nasal cannula STAT
- Vital signs with PO_2 every 5 minutes until stable
- Notify the physician of reaction. Request further orders as indicated
- Complete adverse drug reaction PowerForm and document in the allergy profile for all drug reactions.

Provider Signature: _____ Date: _____

Provider Name and Credentials (please print): _____ Time: _____

Office Phone: _____ Office Fax: _____