McLeod Health

Place Sticker Here

Iron Replacement Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Diagnosis (select one):

☐ D50.9 Iron deficiency Anemia, unspecified ☐ D50.0 Iron deficiency Anemia secondary to blood loss

☐ Other: ICD 10 Code: _____ Diagnosis Description: _____

Pre-Medications: **administered 30 minutes prior to infusion**

☐ None

☐ Acetaminophen 650 mg PO

☐ Diphenhydramine: Dose: ☐ 25 mg ☐ 50 mg Route: ☐ PO or ☐ IVP

☐ Methylprednisolone: Dose: ☐ 40 mg or ☐ 125 mg Route: IVP

☐ Other (include drug, dose, and route): _____

Drug Orders (select iron product and dosing below):

☐ Iron Sucrose (Venofer) (J1756) via IV route

Dosing: ☐ 200 mg ☐ 300 mg ☐ 400 mg ☐ 500 mg

Frequency: ☐ Once ☐ Daily x ____ days ☐ Weekly ☐ Every 2 Weeks ☐ Monthly

Number of Doses: _____

☐ Other: _____

Lab Orders:

☐ _____

Standing Orders:

● Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion/injection will be stopped and physician notified.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Pre-Screening Requirements:

● Hemoglobin, Hematocrit, and iron studies including serum iron, total iron binding capacity, serum ferritin, and transferrin saturation (if available)

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received iron replacement at another facility, please provide last date received: _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Clarendon: 803-435-3194 (Fax)

803-435-3226 (Phone)