

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.

Dillon: 843-487-1491 (Fax)

843-487-1334 (Phone)