McLeod Health

Iron Replacement Treatment Plan

Patient Name: _____ DOB: _____

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

Patient Primary Phone Number: _____

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**

☐ Acetaminophen 650 mg PO

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

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

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: _____

☐ Feruoxytol (Feraheme) (Q0138) 510 mg IV over 15 minutes every 7 days for two doses

☐ Ferric Carboxymaltose (Injectafer) (J1439) via IV route

Dosing: ☐ 750 mg IV over 30 minutes every 7 days for two doses

☐ 15 mg/kg IV over 30 minutes every 7 days for two doses (for patients LESS than 50 kg)

☐ Ferric Gluconate (Ferrlecit) (J2916) via IV route over 60-120 minutes

Dosing: ☐ 125 mg ☐ 250 mg

Frequency: ☐ Once ☐ Daily x _____ days ☐ Weekly ☐ Other: _____

Number of Doses: _____

☐ Ferric Derisomaltose (Monoferric) (J1437) via IV route

Dosing: ☐ 1000 mg IV over 20 minutes for one dose

☐ 20 mg/kg IV over 20 minutes for one dose (for patients LESS than 50 kg)

☐ Other: _____

• Order Duration: One year unless otherwise specified (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.

• Appropriate access and line care orders per health system policy

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 Information:

Insurance Plan Name: _____

Insurance Identification Number: _____

Insurance Customer Service Contact Number: _____

Preferred Treatment Location

☐ McLeod Regional Medical Center (Florence) ☐ McLeod Health Loris ☐ McLeod Health Cheraw

☐ McLeod Health Seacoast (Little River) ☐ McLeod Health Dillon ☐ McLeod Health Clarendon (Manning)

Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798. For any questions, please contact our team at medicationaccessteam@mcleodhealth.org.