Iron Sucrose (VENOFER) Infusion

Weight: _________ kg  Height: _________ cm

Allergies: ____________________________________________________________

Diagnosis Code: ______________________________________________________

Treatment Start Date: ______________  Patient to follow up with provider on date: ______________

**This plan will expire after 365 days at which time a new order will need to be placed**

GUIDELINES FOR ORDERING

1. Send FACE SHEET and H&P or most recent chart note.
2. Provider must order and obtain a ferritin prior to patient being scheduled for iron infusion. Labs drawn date: ________________

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and notify provider if Ferritin greater than 300 ng/mL.
2. Instruct patient to obtain ferritin lab 30 days after infusion treatment and set up follow up appointment with provider.
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

MEDICATIONS:

**iron sucrose (VENOFER): (must check one)**

- 100 mg in sodium chloride 0.9% 50 mL, intravenous, ONCE, over 30 minutes
- 200 mg in sodium chloride 0.9% 100 mL, intravenous, ONCE, over 30 minutes
- 300 mg in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 1.5 hours
- 400 mg in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 2.5 hours
- 500 mg in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 4 hours
- _________ mg in sodium chloride 0.9%, intravenous, ONCE, over _________ (Pharmacy to prepare in an appropriate volume)

No test dose needed. May run NaCl 0.9% 500 mL to decrease vein discomfort.

**Interval: (must check one)**

- Once
- Daily x ______ doses
- Every other day x ___ doses
- Every _____ weeks x ___ doses
- Monthly x ___ doses
- Other: ____________________________
AS NEEDED MEDICATIONS:
1. sodium chloride 0.9%, 500 mL, intravenous, AS NEEDED x1 dose for vein discomfort. Give concurrently with iron sucrose

HYPERSENSITIVITY MEDICATIONS:
1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydramine (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction
3. epinephrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction
5. famotidine (PEPCID) IV, 20 mg, intravenous, AS NEEDED x1 dose, for hypersensitivity reaction

By signing below, I represent the following:
I am responsible for the care of the patient (who is identified at the top of this form);
I hold an active, unrestricted license to practice medicine in: □ Oregon □ ________________ (check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon);

My physician license Number is # ________________ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _______________________ Date/Time: ______________________
Printed Name: _______________________ Phone: ______________ Fax: ______________
OLC Central Intake Nurse:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient’s preferred clinic location:

- **Beaverton**
  - OHSU Knight Cancer Institute
  - 15700 SW Greystone Court
  - Beaverton, OR 97006
  - Phone number: 971-262-9000
  - Fax number: 503-346-8058

- **NW Portland**
  - Legacy Good Samaritan campus
  - Medical Office Building 3, Suite 150
  - 1130 NW 22nd Ave.
  - Portland, OR 97210
  - Phone number: 971-262-9600
  - Fax number: 503-346-8058

- **Gresham**
  - Legacy Mount Hood campus
  - Medical Office Building 3, Suite 140
  - 24988 SE Stark
  - Gresham, OR 97030
  - Phone number: 971-262-9500
  - Fax number: 503-346-8058

- **Tualatin**
  - Legacy Meridian Park campus
  - Medical Office Building 2, Suite 140
  - 19260 SW 65th Ave.
  - Tualatin, OR 97062
  - Phone number: 971-262-9700
  - Fax number: 503-346-8058

Infusion orders located at: [www.ohsu knight.com/infusionorders](http://www.ohsu knight.com/infusionorders)