



Venofer (iron sucrose) IV Infusion Order Form

Phone: 405-442-7577 Fax:405-442-7223

Email: orders@premierinfusioncenter.com

Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / ____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **Weight:** _____ kg **Height:** _____ cm/in
- **Allergies:** NKDA _____
- **Treatment Status:** New Continued **Last Treatment Date:** ____ / ____ / ____

Diagnosis (ICD-10 Selection)

- D50.9 – Iron deficiency anemia, unspecified
- D50.0 – Iron deficiency anemia secondary to blood loss
- N18.6 – End-stage renal disease
- Other: _____ **ICD-10 Code:** _____

Infusion Order

- Venofer 200 mg IV in 100 mL 0.9% sodium chloride over 30 minutes
- Venofer ____ mg IV in 100 mL 0.9% sodium chloride over 30 minutes

- Frequency: Weekly 3 times weekly Other: _____
- Maximum total dose: 1000 mg (over 5 weeks)
- Observation: 30 minutes post-infusion
- Refills: None 12 months Other: _____

Line Use & Access

- Start PIV Access CVC Use PICC Line Flush per standard infusion protocol

Adverse Reaction & Anaphylaxis Orders

- Premier Infusion Center Protocol (premierinfusioncenter.com)
 Other – please fax preferred reaction orders to 405-442-7223

Premedication (Optional)

- Acetaminophen: 650 mg PO
 Diphenhydramine: 25 mg 50 mg PO IV
 Methylprednisolone: 40 mg 125 mg IV
 Other: _____ **Dose:** _____ **Route:** _____

Laboratory Monitoring

- CBC CMP Ferritin Transferrin saturation
 Hemoglobin & Hematocrit
 Other: _____
Frequency: Prior to first dose Weekly Monthly Other: _____
 Physician office will order labs only

Clinical Documentation Checklist

- Recent progress notes Last H&P Lab results Medication list
 Documentation of oral iron failure or intolerance
 Supporting labs within 14 days (CBC, ferritin, TSAT)

Ordering Provider & Demographics

- **Name:** _____
- **NPI:** _____ **License #:** _____
- **Contact:** _____ **Phone:** _____ **Fax:** _____
- **Email:** _____
- **Signature:** _____ **Date:** ____ / ____ / ____