ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER	
ALLERGIES/REACTIONS (REQUIRED):	Yakima Outpatient Infusion Care 808 N 39th Ave Yakima WA 98902 Phone: 509-575-1174 Fax: 509-577-5021
ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.
CODE STATUS	Patients will be considered FULL CODE unless marked otherwise. If the patient has a POLST, advance directive, or living will, please include a copy with the orders.

PARENTERAL IRON REPLACEMENT (PEDIATRIC)

Patient Name:_____ Requested Start Date: _____/_____/_____
Date of Birth:_____/_____/_____ Patient Weight: _____ kg Patient Height: _____

DIAGNOSIS & ICD-10 CODE: _____

REQUIRED: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with this order, scheduling of treatment will be delayed until complete information is available

REQUIRED BASELINE LABS & INFORMATION:

- ✓ Documentation of failed oral iron therapy or oral iron therapy intolerance/contraindication
- ✓ Recent CBC
- ✓ Confirmed diagnosis of a microcytic anemia with low MCV and high RDW and/or
- ✓ Recent Iron studies showing need for iron replacement (TIBC, % iron saturation, ferritin, serum iron)

ACCESS: *Access and maintain IV site or Port-A-Cath in accordance with the appropriate MYM OIC P&Ps*

TREATMENT REGIMEN:

✓ **PRE-MEDICATIONS** – Give 30 minutes prior to infusion
- ❑ Acetaminophen _____ mg PO x 1 dose
- ❑ Diphenhydramine _____ mg PO x 1 dose (or loratadine _____ mg PO x1 if intolerant to diphenhydramine)
- ❑ Other: _____

✓ **PARENTERAL IRON PRODUCT**
Pharmacy to select product based on insurance formulary and dose based on Hgb and weight

MONITORING: Vitals at baseline and at completion of infusion.
SUPPORTIVE CARE: Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.

DISCHARGE: 30 minutes after infusion or injection is complete when vital signs are stable and hypersensitivity symptoms are absent. Waiting period can be waived by patient on subsequent infusions or injections.

Provider Signature: _____ Date: _____
Print name: _____ Phone # _____ Fax # _____

****FOR PHARMACY USE ONLY – PRODUCT SELECTION PER THIRD-PARTY PREFERENCE – DOSE BASED ON HGB & WEIGHT****
Calculated iron deficit: _____ mg

- ❑ Ferric carboxymaltose: _____ mg (diluted) IV weekly over 15 minutes for _____ dose(s)
- ❑ Iron dextran: _____ mg (diluted) IV infused at 1 g/hr every _____ weeks for _____ doses. (max 1000 mg/dose)
  Initial doses will be given with a 25 mg IV test dose over 5 minutes with a 15 minute wait until the remainder of the dose is administered. Subsequent doses may be given without a test dose prior.
- ❑ Other: _____

Pharmacist signature: _____ Date: _____

****Expires 12 months from written date****

Patient Identification - Attach Patient Label

Name:

MRN:

Age / Sex and Gender:

PARENTERAL IRON REPLACEMENT
MultiCare
Yakima Memorial Hospital