BioPlus® Infusion

Fax your completed order to 877-734-1157

Patient Name: _____ DOB: _____ Date of Last Infusion: _____
Height _____ Weight _____
Infusion Location: (state and site) _____

Venofer® (iron sucrose) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ Iron Deficiency Anemia (ICD-10) _____ Chronic Kidney Disease: Stage ☐ 1 ☐ 2 ☐ 3 ☐ 4 (ICD10)

_____ Other: _____ (ICD-10) _____ Other _____ (ICD-10)

Nursing Orders:

- Hold infusion and notify provider for signs or symptoms of illness or active infection
- Monitor for hypotension
- Record vital signs before and after infusion, or at least every 30 minutes
- Instruct patient to complete follow-up lab testing as ordered below
- If infusion-related reaction occurs, stop infusion and initiate Hypersensitivity Reaction Management Protocol as clinically indicated

Pre-medications (consider in presence of risk factors for hypersensitivity reaction: Age >65 years, weight <50 kg, hx asthma or severe cardiac or respiratory disease, multiple drug allergies or hx hypersensitivity reaction. Smaller doses may also be indicated in these patients):

☐ Solu-Medrol 125 mg IVP once 30 minutes prior to infusion ☐ Other: _____

☐ Iron sucrose 100 mg in 100 ml 0.9% sodium chloride x _____ doses (max 10). Infuse over 15 minutes. Schedule infusions at least 24 hours apart.

☐ Iron sucrose 200 mg in 100 ml 0.9% sodium chloride x _____ doses (max 5). Infuse over 15 minutes. Schedule infusions at least 24 hours apart.

☐ Iron sucrose 300 mg in 250 ml 0.9% sodium chloride x _____ doses (max 3). Infuse over 90 minutes. Schedule infusions once per week.

Observation Period:

- Monitor patient for hypersensitivity reaction for a period of 30 minutes following each infusion
- Record vital signs prior to discharge

Follow-up Lab Orders: At least 48 hours following last iron infusion, draw the following:

☐ CBC w/diff, ferritin, transferrin saturation, TIBC

RN: Fill in date and provide order to patient: Draw on or after _____

Additional Orders:

_____

_____

Provider Name (print): _____ Date: _____

Provider Signature: _____ Time: _____