Peritoneal Dialysis Programs Standing Orders – Iron

Iron Sucrose (Venofer) (ICD10 = D63.1)

1. **Goal:** Iron saturation 25 - 35%; Ferritin <800 ng/ml.
2. **Labs:** (ICD10 = E83.10)
   a. Draw iron studies (iron saturation and ferritin) monthly until TSAT ≥ 25% then quarterly in January, April, July and October.
   b. Iron labs must be drawn at least 7 days after last IV iron dose or transfusion. May wait until next monthly lab draw.
3. **ESA:** Do not start ESA until iron saturation is ≥ 25%.
4. **Administration:** Dilute in a minimum of 50 ml NS for IV infusion over 20 – 30 minutes.
5. **Dosing:**
   a. **First Dose:** Observe the patient in the dialysis unit for 30 minutes following the initial dose of IV iron to watch for possible drug reactions.
   b. Patients transferring from in-center will be converted to Iron Sucrose (Venofer) per home dialysis programs iron protocol.
   c. Based on patient's most recent iron studies give Iron Sucrose (Venofer) per tables below:

If	And	And		
New to PD Program	**Ferritin**	**Iron Saturation**	**Timing**	**Iron Sucrose (Venofer) Dose**
	≤ 800	< 25%	1st week (Training)	Give 200 mg
			2nd week	Give 200 mg
		25 - 35%	1st week (training)	Give 200 mg
		> 35%		Hold Iron Sucrose (Venofer)
	> 800	< 25%		Check with nephrologist
		≥ 25%		Hold Iron Sucrose (Venofer)

Patient Name_____ **NKC#**_____

If	And	And		
	Ferritin	**Iron Saturation**	**Timing**	**Iron Sucrose (Venofer) Dose**
Maintenance PD Program	≤ 800	< 25%		Give 200 mg q 2 weeks x 2 doses and recheck iron studies at next monthly visit.
		25 - 35%		Give 200 mg
		> 35%		Hold Iron Sucrose (Venofer)
	> 800	< 25%		Check with nephrologist
		≥ 25%		Hold Iron Sucrose (Venofer)

6. **Hemoglobin:**
   a. If hemoglobin ≥12, iron saturation ≥25%, and ferritin ≥800, hold Iron Sucrose (Venofer).
   b. If hemoglobin ≥12, iron saturation ≤25%, and ferritin ≤800, contact MD for direction.
   c. If hemoglobin ≥12, iron saturation ≤25%, and ferritin ≥800, contact MD for direction.
7. **Infection/Antibiotics:** HOLD IV iron if patient has signs of significant infection or is on antibiotics.

_____
Physician Name (Please Print)

_____ _____
Physician signature Date
(see referral sheet)

Patient Name_____ **NKC#**_____