Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071

ADULT AMBULATORY INFUSION ORDER

Deferoxamine (DESFERAL)

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

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. Avoid concurrent ascorbic acid (Vitamin C) use. If supplementation is necessary, ascorbic acid may be given after one month of regular treatment with deferoxamine and should not exceed 200 mg/day (in divided doses). Monitor cardiac function.
3. Ascorbic acid supplements should not be given to patients with cardiac failure.
4. Perform periodic ophthalmic and audiology exams in patients who have received deferoxamine over prolonged periods of time, at high doses, or who have low ferritin levels.

LABS:

- ☐ CMP, Routine, ONCE
  prior to therapy and every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Ferritin (serum), Routine, ONCE
  prior to therapy and every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Iron and TIBC (serum), Routine, ONCE
  prior to therapy and every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Labs already drawn. Date: _____

MEDICATIONS:

deferoxamine (DESFERAL) in NaCl 0.9% 500 mL, intravenous, ONCE

Initial Dose:
- ☐ 500 mg
- ☐ 1000 mg

Maintenance Dose:
- ☐ 500 mg
- ☐ 1000 mg

Interval for maintenance dose: ***(must check one)***
- ☐ Once
- ☐ Once daily x _____ doses
- ☐ Once a week x _____ doses
- ☐ Twice a week x _____ doses
- ☐ Three times per week x _____ doses

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NURSING ORDERS:

1. Infuse initial dose of 500-1000 mg at a rate NTE 15 mg/kg/hr. Subsequent maintenance doses should not exceed 125 mg/hr.
2. Inform patient that deferoxamine may cause a reddish discoloration of the urine.
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

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). 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

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**: _____

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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.ohsuknight.com/infusionorders