



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

PO7071



ADULT AMBULATORY INFUSION ORDER

**Ferric Carboxymaltose
(INJECTAFER) Infusion**

Page 1 of 3

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. **Ferritin must be obtained within 90 days prior to start of treatment. Labs drawn date:** _____

MEDICATIONS:

ferric carboxymaltose (INJECTAFER): (must check one)

- Weight 50 kg or greater – 750 mg in NaCl 0.9% 250 mL, intravenous, ONCE, over 30 minutes
- Weight less than 50 kg – 15 mg/kg = _____ mg in NaCl 0.9%, intravenous, ONCE, over 30 minutes (Pharmacy to prepare in an appropriate volume)

Avoid extravasation (may cause persistent discoloration). Monitor, if extravasation occurs, discontinue administration at that site.

Interval: (must check one)

- 2 doses at least 7 days apart
- Other: _____

NURSING ORDERS:

1. Monitor the patient for signs and symptoms of hypersensitivity during the infusion and for at least 30 minutes after completion of the infusion. Also monitor BP following infusion.
2. TREATMENT PARAMETER – Ferritin must be obtained within 90 days prior to start of treatment. Hold Ferric Carboxymaltose and notify provider if Ferritin greater than 300
3. TREATMENT PARAMETER – For iron deficient anemia, a CBC, TIBC and Ferritin must be obtained within 90 days of the start of treatment
4. Remind patient to contact provider to set up lab draw, approximately 4 weeks after treatment infusion.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.



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

ADULT AMBULATORY INFUSION ORDER

**Ferric Carboxymaltose
(INJECTAFER) Infusion**

Page 2 of 3

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

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
5. famotidine (PEPCID) IV, 20 mg, intravenous, AS NEEDED x1 dose, for hypersensitivity reaction

AS NEEDED MEDICATIONS:

1. sodium chloride 0.9%, 500 mL, intravenous, AS NEEDED x1 dose for vein discomfort. Give concurrently with ferric carboxymaltose

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:** _____



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

ADULT AMBULATORY INFUSION ORDER

**Ferric Carboxymaltose
(INJECTAFER) Infusion**

Page 3 of 3

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

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