



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

PO7071



ADULT AMBULATORY INFUSION ORDER  
**Ferumoxytol (FERAHEME) 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. **Ferritin must be obtained within 90 days prior to start of treatment. Labs drawn date:** \_\_\_\_\_
2. Ferumoxytol administration may alter magnetic resonance (MR) imaging, conduct anticipated MRI studies prior to use.
3. MR imaging alterations may persist for less than or equal to 3 months following use, with peak alterations anticipated in the first 2 days following administration.
4. If MR imaging is required within 3 months after administration, use T1- or proton density-weighted MR pulse sequences to decrease effect on imaging.
5. Do not use T2-weighted sequence MR imaging prior to 4 weeks following ferumoxytol administration.

**MEDICATIONS: (select one)**

- ferumoxytol (FERAHEME) in NaCl 0.9 % (NS) IV, intravenous, administer over 15 minutes
- 510 mg, x 2 doses, Administer dose followed by repeat dose 3-8 days after.

**AS NEEDED MEDICATIONS:**

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

**NURSING ORDERS:**

1. TREATMENT PARAMETERS – Ferritin must be obtained within 90 days prior to start of treatment. Hold Ferumoxytol and notify provider if Ferritin greater than 300.
2. VITAL SIGNS – For Ferumoxytol infusion: Monitor vital signs prior to infusion and at completion of infusion. Monitor for dysphagia, urticaria, flushing, chest pain, lowered blood pressure and pulse (SBP less than 90, HR less than 50 or greater than 140.)
3. Patient may experience hypotension during infusion, ensure patient is in a reclined or semi-reclined position during the ferumoxytol infusion
4. Monitor patient for infusion-related reactions for 60 minutes after completion of first infusion. If no previous infusion reactions, monitoring not required for subsequent doses. Monitoring recommended for previous infusion reactions, contact provider for guidance
5. Remind patient to contact provider to set up lab draw, approximately 4 weeks after treatment infusion
6. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.



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**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, Max dose 50 mg
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, Dilute vial by either pressing chamber for Act-O-Vial or diluting powder vial with 2 mL SWFI or NS for injection.
5. famotidine (PEPCID), 20 mg, intravenous, AS NEEDED x1 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](http://www.ohsuknight.com/infusionorders)