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. For initial therapy: Ferritin must be obtained within 90 days prior to start of treatment.
3. For maintenance therapy: Ferritin labs must be obtained within 60 days prior to administering each subsequent dose

MEDICATIONS:
iron sucrose (VENOFER): (must check one)
- 100 mg in sodium chloride 0.9% 50 mL, intravenous, ONCE, over 30 minutes
- 200 mg in sodium chloride 0.9% 100 mL, intravenous, ONCE, over 30 minutes
- 300 mg in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 1.5 hours
- 400 mg in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 2.5 hours
- 500 mg in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 4 hours
- _________ mg in sodium chloride 0.9%, intravenous, ONCE, over _________ (Pharmacy to prepare in an appropriate volume)

No test dose needed. May run NaCl 0.9% 500 mL to decrease vein discomfort.

Interval: (must check one)
- Once
- Daily x _____ doses
- Every other day x ___ doses
- Every _____ weeks x _____ doses
- Monthly x ____ doses
- Other: _____________________________
NURSING ORDERS:
1. TREATMENT PARAMETER – Ferritin must be obtained within 90 days prior to start of treatment. Hold Iron Sucrose and notify provider if Ferritin greater than 300.
2. TREATMENT PARAMETER – Labs: For initial therapy: Ferritin must be obtained within 90 days of the start of treatment. For maintenance therapy: Ferritin labs must be obtained within 60 days prior to administering each subsequent dose.
3. Instruct patient to obtain ferritin lab 30 days after infusion treatment and set up follow up appointment with provider.
4. 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
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 iron sucrose

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: ____________________________ |
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

- **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

- **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

- **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)