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
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 (Adrenaline) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
4. Famotidine (Pepcid) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. 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: ___________

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