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. Remind patient to contact provider to set up lab draw, approximately 4 weeks after treatment infusion.
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 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: ___________________________
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)