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 prior to start of treatment. Labs drawn date: ____________

NURSING ORDERS:

1. TREATMENT PARAMETERS – Hold treatment and notify provider if Ferritin greater than 300 ng/mL.
2. Monitor patient for signs and symptoms of hypersensitivity during the infusion and for at least 30 minutes after completion of the infusion.
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

MEDICATIONS:

Ferric Derisomaltose (MONOFERRIC) dosing: (must check one)

- For weight greater than or equal to 50 kg:
  1,000 mg in sodium chloride 0.9% 100 mL, intravenous, ONCE, over 20 minutes

- For weight less than 50 kg:
  20 mg/kg in sodium chloride 0.9% 100 mL, intravenous, ONCE, over 20 minutes

AS NEEDED MEDICATIONS:

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

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, HMC C-132). 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) injection, 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: __________________________

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
Tualatin 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.ohsknight.com/infusionorders