ADULT AMBULATORY INFUSION ORDER
Deferoxamine (DESFERAL) Infusion

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 sodium chloride 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 (OHSU 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 x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion 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: _______________

Central Intake:
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