



Oregon Health & Science University  
Hospital and Clinics Provider's Orders

PO7071



ADULT AMBULATORY INFUSION ORDER  
**Deferoxamine (DEFERAL)  
Infusion**

Page 1 of 3

ACCOUNT NO.  
MED. REC. NO.  
NAME  
BIRTHDATE

Patient Identification

**ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.**

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 (DEFERAL) 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



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**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



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**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](http://www.ohsuknight.com/infusionorders)