
 <div style="text-align: center;"> Oregon Health & Science University Hospital and Clinics Provider's Orders </div> <div style="text-align: center; margin-top: 10px;">  </div> <div style="text-align: center; margin-top: 10px;"> <small>ADULT AMBULATORY INFUSION ORDER</small> Ferric Derisomaltose (MONOFERRIC) Infusion <small>Page 1 of 2</small> </div>	<div style="margin-top: 20px;"> ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE </div> <div style="text-align: right; margin-top: 20px; font-size: small;"> <i>Patient Identification</i> </div>
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. 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, declothing (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 (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



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

ADULT AMBULATORY INFUSION ORDER

**Ferric Derisomaltose
(MONOFERRIC) Infusion**

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ACCOUNT NO.

MED. REC. NO.

NAME

BIRTHDATE

Patient Identification

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

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