
 <div style="text-align: center;"> <b>Oregon Health &amp; Science University</b>  <b>Hospital and Clinics Provider's Orders</b> </div> <div style="text-align: center; margin-top: 10px;">  </div> <div style="text-align: center; margin-top: 10px;"> <small>ADULT AMBULATORY INFUSION ORDER</small>  <b>Sodium Ferric Gluconate Complex</b>  <b>(FERRLECIT) Infusion</b>  <small>Page 1 of 3</small> </div>	<div style="margin-bottom: 5px;">ACCOUNT NO. _____</div> <div style="margin-bottom: 5px;">MED. REC. NO. _____</div> <div style="margin-bottom: 5px;">NAME _____</div> <div style="margin-bottom: 5px;">BIRTHDATE _____</div> <div style="text-align: right; font-size: small; margin-top: 20px;"><i>Patient Identification</i></div>
<b>ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK ( ✓ ) TO BE ACTIVE.</b>	

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. If patient is pregnant, estimated due date is: \_\_\_\_\_.
3. Provider must order and obtain ferritin prior to patient being scheduled for iron infusion.  
     Labs drawn date: \_\_\_\_\_.  
     Copy of ferritin result must be attached.
4. Many insurance providers require a ferritin result within 90 days. If ferritin is not within 90 days of signed date then patient's insurance may deny coverage for this treatment.

**NURSING ORDERS:**

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

**MEDICATIONS:**

sodium ferric gluconate complex (FERRLECIT) 125 mg in sodium chloride 0.9% 100 mL, intravenous, over 1 hour

**Interval:**

- ☐ Once
- ☐ Other: \_\_\_\_\_

**AS NEEDED MEDICATIONS:**

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



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

ADULT AMBULATORY INFUSION ORDER  
**Sodium Ferric Gluconate Complex  
(FERRLECIT) Infusion**

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ACCOUNT NO.  
MED. REC. NO.  
NAME  
BIRTHDATE

*Patient Identification*

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**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. NURSING COMMUNICATION – Avoid intravenous or oral diphenhydramine, move to next option in the algorithm. Adverse effects of diphenhydramine may overlap with IV iron adverse effects such as flushing, hypotension, tachycardia.
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:** \_\_\_\_\_

 <p><b>Oregon Health &amp; Science University</b> Hospital and Clinics Provider's Orders</p> <p>ADULT AMBULATORY INFUSION ORDER <b>Sodium Ferric Gluconate Complex</b> <b>(FERRLECIT) Infusion</b> Page 3 of 3</p>	<p>ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE</p> <p style="text-align: right;"><i>Patient Identification</i></p>
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Central Intake:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

***Please check the appropriate box for the patient's preferred clinic location:***

- |   |   |
|---|---|
| <p><input type="checkbox"/> <b>Beaverton</b><br/>OHSU Knight Cancer Institute<br/>15700 SW Greystone Court<br/>Beaverton, OR 97006<br/>Phone number: 971-262-9000<br/>Fax number: 503-346-8058</p>                        | <p><input type="checkbox"/> <b>NW Portland</b><br/>Legacy Good Samaritan campus<br/>Medical Office Building 3, Suite 150<br/>1130 NW 22nd Ave.<br/>Portland, OR 97210<br/>Phone number: 971-262-9600<br/>Fax number: 503-346-8058</p> |
| <p><input type="checkbox"/> <b>Gresham</b><br/>Legacy Mount Hood campus<br/>Medical Office Building 3, Suite 140<br/>24988 SE Stark<br/>Gresham, OR 97030<br/>Phone number: 971-262-9500<br/>Fax number: 503-346-8058</p> | <p><input type="checkbox"/> <b>Tualatin</b><br/>Legacy Meridian Park campus<br/>Medical Office Building 2, Suite 140<br/>19260 SW 65th Ave.<br/>Tualatin, OR 97062<br/>Phone number: 971-262-9700<br/>Fax number: 503-346-8058</p>    |

Infusion orders located at: [www.ohsuknight.com/infusionorders](http://www.ohsuknight.com/infusionorders)