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

PO7071

ADULT AMBULATORY INFUSION ORDER

Hemin (PANHEMATIN) Infusion

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. An appropriate period of carbohydrate loading should be determined to be given prior to hemin administration. Manufacturer packaging describes 400 g glucose/day for 1 to 2 days. Provider will instruct patient of plan if orally loading at home prior to appointments. Oral loading is preferred. If patient is unable to tolerate oral loading, intravenous dextrose infusions are available. Infusion clinics may be limited in capacity for administering more than 2 liters of dextrose 10% (200 g dextrose) intravenously in a single day given operating hours and time constraints. Dextrose 10% infusions are given central line only.
3. Repeat administration cycles may result in iron overload; monitor iron and serum ferritin.
4. Asymptomatic oliguria, increased nitrogen retention and reversible renal shutdown has been observed (case report).
5. Transient, mild anticoagulation effects have been observed, although the extent and duration of hypercoagulation have not been determined. Avoid concurrent anticoagulation therapy.
6. Product of human plasma; may potentially contain infectious agents that could transmit disease, including a theoretical risk of Creutzfeldt-Jakob disease. Screening of donors, as well as testing and/or inactivation or removal of certain viruses, reduces the risk. Infections thought to be transmitted by this product should be reported to Recordati Rare Diseases at 1-888-575-8344.
7. Hemin can cause phlebitis at the site of infusion. Utilize a large vein or a central venous catheter for administration.

LABS:

- ☐ Ferritin, Routine, ONCE, every 8 weeks
- ☐ Iron and TIBC, Routine, ONCE, every 8 weeks
- ☐ CMP, Routine, ONCE, every visit

NURSING ORDERS:

1. Hemin can cause phlebitis at the site of infusion. Utilize a large vein or a central venous catheter for administration.
2. Hemin orders must be administered immediately upon preparation as the product degrades quickly. Hemin orders should be released and prepared when ready to be administered. Contact Infusion pharmacy for coordinated preparation. Flush with 100 mL 0.9% sodium chloride. Infuse using a 0.45 micron or smaller filter.
3. Patient should receive glucose loading prior to hemin treatments. This can be done orally or intravenously. This is typically given as 300-400 g of glucose daily on days 1-2 of a treatment course,

but variations in dose and frequency exist. Intravenous dextrose 10% infusion are to be administered CENTRAL LINE ONLY at a rate not exceeding 5 mL/kg/hour to prevent glycosuria.

4. If patient has been instructed to carbohydrate load prior to appointments - confirm patient completed pre-treatment doses. Hold hemin and contact provider if patient has not carbohydrate loaded by mouth as instructed. If IV dextrose 10% is ordered, proceed with Hemin infusion as ordered. Okay to proceed with Hemin alone on subsequent days of treatment cycle after glucose loading complete.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

PRE-MEDICATIONS:

Dextrose (D10) 10% bolus, 1,000 mL, intravenous, ONCE, at rate 5 mL/kg/hr

Interval: (must check one)
☐ Day 1 of hemin infusion
☐ Day 1 and day 2 of hemin infusion
☐ Daily on days _____ of hemin infusion

MEDICATIONS:
Provider to Pharmacist Communication, Every Visit. For 3-4 mg/kg dosing, round dose to nearest vial size (350 mg). Dose should NOT exceed 6 mg/kg. For patients weighing < 60 kg, round dose to nearest 7 mg dose.

Patient ≥ 60 kg
☐ hemin (PANHEMATIN), 350 mg, in 50 mL sterile water, intravenous, over 30 minutes, ONCE

Patient ≤ 60 kg
☐ hemin (PANHEMATIN), 3 mg/kg, in sterile water, intravenous, over 30 minutes, ONCE
☐ hemin (PANHEMATIN), 4 mg/kg, in sterile water, intravenous, over 30 minutes, ONCE

Interval: (must check one)
☐ Daily x _____ doses
☐ Daily x _____ doses, repeated every _____ days

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 or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 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) 20 mg, intravenous, AS NEEDED x1 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