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

MEDICATIONS: ***(must select between single or two-dose regimen, and must check one dose)***

ferric carboxymaltose (INJECTAFER) injection. Avoid extravasation (may cause persistent discoloration). Monitor, if extravasation occurs, discontinue administration at that site. For ambulatory infusion, monitor for 30 minutes post infusion.

- **SINGLE DOSE REGIMEN:**

  Dose:
  - ☐ Weight 50 kg or greater **–** 1000 mg in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 30 minutes, or 50 mg/mL IV push over 15 minutes per infusion facility practice.
  - ☐ Weight less than 50 kg **–** 15 mg/kg = _____ mg in sodium chloride 0.9%, intravenous, ONCE, over 30 minutes (Pharmacy to prepare in an appropriate volume), or 50 mg/mL IV push over 10-15 minutes per infusion facility practice.

  Interval:
  - ☑ Once

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- **TWO DOSE REGIMEN:**

  Dose:
  - ☐ Weight 50 kg or greater – 750 mg in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 30 minutes, or 50 mg/mL IV push over 10 minutes per infusion facility practice.
  - ☐ Weight less than 50 kg – 15 mg/kg = _____ mg in sodium chloride 0.9%, intravenous, ONCE, over 30 minutes (Pharmacy to prepare in an appropriate volume), or 50 mg/mL IV push over 10-15 minutes per infusion facility practice.

  Interval:
  - ☑ 2 doses at least 7 days apart

AS NEEDED MEDICATIONS:

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

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:** _____

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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