



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

PO9031



ADULT AMBULATORY INFUSION ORDER

**Ferric Carboxymaltose
(INJECTAFER) 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. 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. Ferric Carboxymaltose is available as a single-dose regimen (MAX dose 1,000 mg) or two-dose regimen (MAX dose 750 mg, cumulative 1,500 mg for course). Dosing varies based on indication and is dependent on patient weight.
5. 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, declothing (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: _____

Printed Name: _____ Phone: _____ Fax: _____



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Please indicate the patient's preferred clinic location below

<input type="checkbox"/> HILLSBORO MEDICAL CENTER 364 SE 8th Ave, Medical Plaza Suite 108B, Hillsboro, OR 97123	Phone (503) 681-4124 Fax (503) 681-4120
<input type="checkbox"/> ADVENTIST HEALTH – PORTLAND Infusion Services, 10123 SE Market St, Portland, OR 97216	Phone (503) 261-6631 Fax (503) 261-6756
<input type="checkbox"/> ADVENTIST HEALTH – COLUMBIA GORGE Celilo Cancer Center, 1800 E 19th St, The Dalles, OR 97058	Phone (541) 296-7585 Fax (541) 296-7610