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| **Oregon Health & Science University**<br>**Hospital and Clinics Provider's Orders**<br>PO9031<br>ADULT AMBULATORY INFUSION ORDER<br>**Ferric Derisomaltose (MONOFERRIC) Infusion**<br>Page 1 of 2 | ACCOUNT NO.<br>MED. REC. NO.<br>NAME<br>BIRTHDATE<br>*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. 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, declotting (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

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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:** _____

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

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610