LEGACY HEALTH	**Legacy Day Treatment Unit Provider's Orders** Adult Ambulatory Infusion Order FERRIC CARBOXYMALTOSE (INJECTAFER)	**Patient Name:** **Date of Birth:** **Med. Rec. No** (TVC MRN Only):
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE		

Anticipated Start Date: _____ **Patient to follow up with provider on date:** _____
*****This plan will expire after 365 days, unless otherwise specified below*****
Orders expire: _____

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis: _____

Diagnosis Codes: _____ (please include primary and secondary diagnosis codes)

GUIDELINES FOR PRESCRIBING:

1. Send **FACE SHEET, INSURANCE CARD and most recent provider chart or progress note.**
2. Consider ordering a ferritin level before initiating therapy as some insurances may require this for prior authorization. Labs drawn date: _____.

NURSING ORDERS:

1. TREATMENT PARAMETER – For iron deficiency anemia: hold treatment and notify provider if Ferritin greater than 300 ng/mL.
2. Remind patient to contact provider to set up lab draw, approximately 4 weeks after completion of treatment.
3. Nursing communication order, every visit: Manage line per LH policy 904.4007 IV Catheter Insertion (Peripheral) and LH 904.4004 IV Access: Central Catheters.
4. Nursing communication order, every visit: Monitor patient for potential adverse effects (ADEs) during and after infusion: ADEs may include hypersensitivity reactions and hypertension.
5. Nursing communication orders, every visit: Manage hypersensitivity reactions per LH 906.6606.
6. Nursing communication orders, every visit: Monitor for signs and symptoms of hypersensitivity during infusion and 30 minutes following completion.

MEDICATIONS:

☑ ferric carboxymaltose (INJECTAFER) 15 mg/kg (maximum 750 mg) in NaCl 0.9% 250 mL over 15 minutes

Interval: (must check one)

☐ Once
☐ 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

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HYPERSENSITIVITY MEDICATIONS: 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 (Protocol 906.6606, Initiation of Emergency Measures for Adult Oncology and Infusion Clinic Patients). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.

1. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
2. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. albuterol (PROVENTIL HFA) inhaler, 4 puff, inhalation, EVERY 4 HOURS PRN for wheezing
5. 0.9% NaCl, 500 mL, intravenous, CONTINOUS PRN for hypersensitivity/infusion reaction

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

☐ **Legacy Day Treatment Unit – The Vancouver Clinic Building**
A department of Salmon Creek Medical Center
700 NE 87th Avenue, Suite 360
Vancouver, WA 98664
Phone number: 360-896-7070
Fax number: 360-487-5773

☐ **Legacy Salmon Creek Day Treatment Unit**
Legacy Salmon Creek Medical Center
2121 NE 139th Street, Suite 110
Vancouver, WA 98686
Phone number: 360-487-1750
Fax number: 360-487-5773

☐ **Legacy Emanuel Day Treatment Unit**
A department of Emanuel Medical Center
501 N Graham Street, Suite 540
Portland, OR 97227
Phone number: 503-413-4608
Fax number: 503-413-4887

☐ **Legacy STEPS Clinic**
A department of Silverton Medical Center
Legacy Woodburn Health Center
1475 Mt Hood Ave
Woodburn, OR 97071
Phone number: 503-982-1280
Fax number: 503-225-8723

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone**: _____ **Fax:** _____

Organization/Department: _____