



St. Charles Health System

Adult Ambulatory Infusion Order
Ferumoxytol (FERAHEME)

Patient Name:
Date of Birth:

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Treatment Start Date: _____ **Allergies:** _____
Weight: _____ **kg** **Height:** _____ **cm**

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety

- 1. FACE SHEET with complete INSURANCE information and patient CONTACT information**
- 2. Recent VISIT NOTE to support treatment (if not available in Epic)**
- 3. LAB RESULTS for any required prescreening (if not available in Epic)**
- 4. DIAGNOSIS CODE** _____
- 5. Patient NAME and DATE OF BIRTH on EVERY page faxed**

GUIDELINES FOR ORDERING

1. Ferumoxytol is contraindicated in patients with a history of allergic reaction to any intravenous iron product.
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.
5. Ferumoxytol administration may alter magnetic resonance (MR) imaging, conduct anticipated MRI studies prior to use.
6. MR imaging alterations may persist for less than or equal to 3 months following use, with peak alterations anticipated in the first 2 days following administration.
7. If MR imaging is required within 3 months after administration, use T1- or proton density-weighted MR pulse sequences to decrease effect on imaging.
8. Do not use T2-weighted sequence MR imaging prior to 4 weeks following ferumoxytol administration.
9. Iron studies should be repeated about 4 weeks after completion of replacement therapy.

NURSING ORDERS:

1. **TREATMENT PARAMETERS** – Hold treatment and notify provider if Ferritin greater than 300 ng/mL and/or TSAT is greater than 20%.
2. **VITAL SIGNS** – For Ferumoxytol infusion: Monitor and record vital signs at conclusion of infusion and immediately prior to discharge.
3. Patient may experience hypotension during infusion, ensure patient is in a reclined or semi-reclined position during the ferumoxytol infusion.
4. Observe for signs or symptoms of hypersensitivity reactions during and for at least 30 minutes following infusion. Hypersensitivity reactions have occurred in patients in whom a previous ferumoxytol dose was tolerated.
5. Instruct patient to set follow up appointment with provider for follow up labs.

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6. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

MEDICATIONS:

Select a dosing regimen:

- Ferumoxytol (Feraheme) **510 mg** in 100 mL 0.9% sodium chloride, IV, administer over 15 minutes, **once weekly for 2 doses**. Administer dose followed by repeat dose 3-8 days after

AS NEEDED MEDICATIONS:

- sodium chloride 0.9%, 500 mL, intravenous, AS NEEDED x1 dose for vein discomfort. Give concurrently with ferumoxytol
- Optional Pre-Medications. Administer 30 minutes prior to each infusion. Select the pre-medications to be given.

Select	Medication	Dose	Route	Frequency
<input type="checkbox"/>	Acetaminophen (Tylenol)	650 mg	PO	Once
<input type="checkbox"/>	Diphenhydramine (Benadryl)	25 mg	<input type="checkbox"/> PO <input type="checkbox"/> IV	Once
<input type="checkbox"/>	Cetirizine (Zyrtec)	10 mg	PO	Once
<input type="checkbox"/>	Famotidine (Pepcid)	20 mg	<input type="checkbox"/> PO <input type="checkbox"/> IV	Once
<input type="checkbox"/>	Methylprednisolone (Solu-Medrol)	<input type="checkbox"/> 40 mg <input type="checkbox"/> 125 mg	IV	Once
<input type="checkbox"/>	Ondansetron (Zofran)	<input type="checkbox"/> 4 mg <input type="checkbox"/> 8 mg	<input type="checkbox"/> PO <input type="checkbox"/> IV	Once
<input type="checkbox"/>	Prochlorperazine (Compazine)	10 mg	<input type="checkbox"/> PO <input type="checkbox"/> IV	Once
<input type="checkbox"/>				

HYPERSENSITIVITY MEDICATIONS:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

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.

- famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
- methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
- epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
- sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
- albuterol 2.5 mg/3 mL nebulize, AS NEEDED x1 dose for hypersensitivity reaction

- Opting out of standard protocol. Alternative orders are attached, or deviations are documented:



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Patient will be treated at the following infusion location:

- St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed