



Patient Name  
DOB  
MRN  
Physician  
FIN

Defaults for orders not otherwise specified below:

- Interval: Every 7 days
- Interval: Every 14 days
- Interval: Every \_\_\_\_ days

Duration:

- 2 treatments
- Until date: \_\_\_\_\_
- 1 year
- \_\_\_\_ # of Treatments

Anticipated Infusion Date \_\_\_\_\_ ICD 10 Code with Description \_\_\_\_\_

Height \_\_\_\_\_ (cm) Weight \_\_\_\_\_ (kg) Allergies \_\_\_\_\_

**Site of Service**

- SH Gerber
- SH Lemmen Holton (GR)
- SH Pennock
- SH United Memorial
- SH Helen DeVos (GR)
- SH Ludington
- SH Reed City
- SH Zeeland

**Provider Specialty**

- Allergy/Immunology
- Infectious Disease
- OB/GYN
- Rheumatology
- Cardiology
- Internal Med/Family Practice
- Other
- Surgery
- Gastroenterology
- Nephrology
- Otolaryngology
- Urology
- Genetics
- Neurology
- Pulmonary
- Wound Care

**Appointment Requests**

- Infusion Appointment Request**  
Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion and possible labs

**Provider Ordering Guidelines**

- ONC PROVIDER REMINDER 15**  
FERRIC CARBOXYMALTOSE (INJECTAFER):  
Patients eligible to receive ferric carboxymaltose infusion include those with iron deficiency defined as ferritin less than 100 mcg/mL and/or iron saturation less than 20%; Patients may be considered with or without anemia; persistently symptomatic patients with low normal iron studies may also be considered for iron therapy.

Prior to initiation of IV iron therapy, patients should be evaluated for overt bleeding and poor dietary iron function tests greater than three times the upper limit of normal, or patient receiving hemodialysis.

Dose of ferric carboxymaltose:

- For patients less than 50 kg, dose is 15 mg/kg.
- For patients greater than or equal to 50 kg, dose is 750 mg.

**Labs**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Hemoglobin + Hematocrit (H+H) | <ul style="list-style-type: none"> <li><input type="checkbox"/> Every ____ days</li> <li><input type="checkbox"/> Once 4 weeks post 2<sup>nd</sup> infusion</li> <li><input type="checkbox"/> Once</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Until date: _____</li> <li><input type="checkbox"/> 1 year</li> <li><input type="checkbox"/> ____ # of Treatments</li> </ul> |
|--|---|--|

Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Ferritin, Blood Level | <ul style="list-style-type: none"> <li><input type="checkbox"/> Every ____ days</li> <li><input type="checkbox"/> Once 4 weeks post 2<sup>nd</sup> infusion</li> <li><input type="checkbox"/> Once</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Until date: _____</li> <li><input type="checkbox"/> 1 year</li> <li><input type="checkbox"/> ____ # of Treatments</li> </ul> |
|--|---|--|

Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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**NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.**



Patient Name  
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**Labs (continued)**

	Interval	Duration
<input type="checkbox"/> Transferrin, Blood Level	<input type="checkbox"/> Every ___ days <input type="checkbox"/> Once 4 weeks post 2 <sup>nd</sup> infusion <input type="checkbox"/> Once	<input type="checkbox"/> Until date: _____ <input type="checkbox"/> 1 year <input type="checkbox"/> _____ # of Treatments

Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous

<input type="checkbox"/> Iron and Iron Binding Capacity Level	<input type="checkbox"/> Every ___ days <input type="checkbox"/> Once 4 weeks post 2 <sup>nd</sup> infusion <input type="checkbox"/> Once	<input type="checkbox"/> Until date: _____ <input type="checkbox"/> 1 year <input type="checkbox"/> _____ # of Treatments
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Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous

**Additional Lab Orders**

	Interval	Duration
<input type="checkbox"/> Labs: _____	<input type="checkbox"/> Every ___ days <input type="checkbox"/> Once	<input type="checkbox"/> Until date: _____ <input type="checkbox"/> 1 year <input type="checkbox"/> _____ # of Treatments

**Nursing Orders**

**ONC NURSING COMMUNICATION 10**  
 FERRIC CARBOXYMALTOSE (INJECTAFER):  
 Concerns related to adverse effects:

- Hypersensitivity: Serious hypersensitivity reactions, including anaphylactic-type reactions (some life-threatening and fatal) have been reported. Monitor during and for at least 30 minutes after administration and until clinically stable. Signs/symptoms of serious hypersensitivity reaction include shock, hypotension, loss of consciousness, and/or collapse. Equipment for resuscitation, medication, and trained personnel experienced in handling emergencies should be immediately available during infusion.
- Hypertension: Transient elevations in systolic blood pressure (sometimes with facial flushing, dizziness, or nausea) were observed in studies; usually occurred immediately after dosing and resolved within 30 minutes. Monitor blood pressure following infusion.

Observe patient for signs and symptoms of hypersensitivity during and after ferric carboxymaltose administration for at least 30 minutes and until clinically stable following completion of each administration.

At the onset of any hypersensitivity reaction, the infusion must be stopped and the ordering physician or on-site nurse practitioner will be notified immediately with emergent medications given under that provider's direction.

Patient may only be discharged if no signs or symptoms of hypertension or hypersensitivity reactions and the patient's vital signs are at baseline.

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**ONC NURSING COMMUNICATION 100**  
 May Initiate IV Catheter Patency Adult Protocol

**Vitals**

**Vital Signs**  
 Routine, PRN, Starting S, Take vital signs at initiation and completion of infusion and as frequently as indicated by patient's symptoms

**Medications**

ferric carboxymaltose (INJECTAFER) in sodium chloride 0.9 % 50 mL IVPB  
 Dose:

- 750 mg
- 15 mg/kg (for patients less than 50 kg)

Intravenous, for 15 Minutes, Once, Starting S, For 1 Dose  
 Infuse over at least 15 minutes. Monitor for hypersensitivity reactions during and for at least 30 minutes after administration, and until clinically stable.

Telephone order/Verbal order documented and read-back completed. Practitioner's initials \_\_\_\_\_

**NOTE:** Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.



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TRANSCRIBED:		VALIDATED:		ORDERED:		Pager #
TIME	DATE	TIME	DATE	TIME	DATE	
	Sign		R.N. Sign		Physician Print	Physician