

Columbus Community Hospital

Columbus, Nebraska

DOCTORS ORDERS

PLEASE NOTE: Condition of Wound, Removal of Stitches, Consultation, Change in Diagnosis, Complications, Condition on Discharge, Instructions of Patient.

PLEASE SIGN AND DATE EACH ENTRY

PLEASE INDICATE / ALLERGIES

NONE	CODEINE	PENICILLIN	SULFA	ASPIRIN	OTHER	HEIGHT
REACTION						WEIGHT

Authorization is granted to supply medications by non-proprietary name unless checked here

**PHYSICIANS ORDERS
(including Medications)**

Ferumoxytol (FERAHEME) Infusion

(8/2024)

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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. Ferumoxytol is contraindicated in patients with a history of allergic reaction to any intravenous iron product.
3. Provider must order and obtain a ferritin prior to patient being scheduled for iron infusion. Labs drawn date: _____
4. Ferumoxytol administration may alter magnetic resonance (MR) imaging, conduct anticipated MRI studies prior to use.
5. 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.
6. If MR imaging is required within 3 months after administration, use T1- or proton density-weighted MR pulse sequences to decrease effect on imaging.
7. Do not use T2-weighted sequence MR imaging prior to 4 weeks following ferumoxytol administration.

NURSING ORDERS:

1. **TREATMENT PARAMETERS** – Hold treatment and notify provider if Ferritin greater than 300 ng/mL.
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.
6. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

PREMEDICATIONS PRIOR TO IRON INFUSION:

- Acetaminophen 975mg PO x 1
OR
- Acetaminophen (Ofirmev) 1000mg IV x 1
- History** of Transfusion Reaction: Solu-Medrol 125mg IV x 1.

(cont.)



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Page 2 of 2

MEDICATIONS: (select one)

- Single-dose regimen: Ferumoxytol 1020mg diluted in 250ml of 0.9% NaCl given IV over 30 minutes x 1.
- Two-dose regimen: Ferumoxytol 510mg diluted in 100ml of 0.9% NaCl given IV over 15 minutes once; After _____ days (3 to 8), administer a second dose of 510mg x 1.

AS NEEDED MEDICATIONS:

1. Sodium chloride 0.9%, 500 mL, intravenous, AS NEEDED x1 dose for vein discomfort. Give concurrently with ferumoxytol.

HYPERSENSITIVITY:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop **STOP THE INFUSION.**
2. Obtain vital signs and continue to monitor vitals every 5 minutes.
3. Notify ordering provider.
4. Refer to **Adult Hypersensitivity (HSR) & Allergic Reaction Management** algorithm for assessment guidelines and interventions.
5. Continue to assess as grade of severity may progress.
6. Administer emergency medications as directed on the physician's orders.

HYPERSENSITIVITY MEDICATIONS:

1. **Acetaminophen, 975 mg, PO, x 1 dose, AS NEEDED** for hypersensitivity or infusion reaction.
2. **Diphenhydramine inj, 50 mg, IV, AS NEEDED** for hypersensitivity or infusion reaction. May repeat x 1 AS NEEDED per reaction management algorithm.
3. **Hydrocortisone Sodium Succinate, 100 mg, IV, AS NEEDED x 1 dose** for hypersensitivity or infusion reaction.
4. **Famotidine, 20 mg, IV, AS NEEDED x 1 dose** for hypersensitivity or infusion reaction.
5. **Oxygen, 2 Liters/min** per nasal cannula for hypersensitivity or infusion reaction.
6. **0.9% Normal Saline, 1000 mL, IV, 150mL/hr, AS NEEDED** for hypersensitivity or infusion reaction.
7. **EPINEPHrine HCl (1mg/1mL), 0.3 mg, IM injection, AS NEEDED x 1 dose** for hypersensitivity or infusion reaction.

My NPI 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: _____

