 <p><b>ADULT AMBULATORY INFUSION ORDER</b>  <b>12/2025</b>  <b>FERRIC DERISOMALTOSE (MONOFERRIC) Infusion</b>  <b>For Medford &amp; Seaside ONLY</b></p>	<p>NAME:          BIRTHDATE:          INSURANCE:          PROVIDER NAME:          CLINIC NAME and Phone number:</p> <p style="text-align: right;">Patient identification</p>
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## **NOTICE: CHANGE IN IRON PRODUCT AVAILABILITY**

**Effective November 4, 2025:** Providence aims to provide the most effective and convenient treatment while minimizing unnecessary appointments and infusion lengths.

**Based on the Outpatient Infusion clinic location, the following Iron products are available:**

### **Medford location:**

*Infed, Feraheme, Injectafer, Venofer, Monoferric & Ferrlecit*

### **Seaside location:**

*Infed, Feraheme, Injectafer, Venofer, Monoferric & Ferrlecit*

### **Providence Portland, Willamette Falls & Newberg locations:**

*Monoferric, Infed & Feraheme ONLY*

### **Review the following ordering instructions for PPMC, Willamette Falls & Newberg:**


\*listed in order of most preferred product (1) to least preferred product (3)

1. Monoferric (ferric derisomaltose):
  - o **If the patient's insurance allows for this product, please send orders for Monoferric. (Medicaid will not cover.)**
  - o This product is not available for pregnant patients.
  - o Please carefully review Monoferric order form for specific diagnosis codes and lab requirements for this treatment.
2. Infed (iron dextran):
  - o **If the patient's insurance does not cover Monoferric, please send orders for Infed.**
  - o If patient is pregnant, please send an order for Infed.
3. Feraheme (ferumoxytol):
  - o If patient cannot receive Monoferric or Infed, please send an order for Feraheme.
  - o Please note: Order for Feraheme will be reviewed by the Infusion Medical Director to determine if we are able to accept the referral.
  - o If it has been determined that OPI cannot accept Feraheme orders, the ordering clinic will be notified.

Thank you for your understanding and cooperation.

Sincerely,

Providence Outpatient Infusion Intake Team

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WEIGHT: \_\_\_\_\_ kg    Height: \_\_\_\_\_ cm    Allergies: \_\_\_\_\_

- 1) Patient name and date of birth must be on EACH page of this order form. This form will be returned if any left blank.
- 2) Send FACE SHEET and complete copy of INSURANCE information. Send H&P or most recent chart note, must be **within the past 12 months**.

**ATTENTION!!! This form is only to be used for Medford & Seaside. Please return to infusion order form website to utilize appropriate form if referring to any other OPI site.**

Note: **Documentation of tried & failed oral iron is required for Monoferric.**

If any section is left incomplete order will not be processed. Send a copy of LOW Ferritin and/or LOW Hemoglobin lab results. ***Labs should be within the last 20 days of date this form is received. If patient's lab results are over 28 days old by the date Monoferric is scheduled, provider will be contacted that new labs are required before we can proceed with Monoferric.***

If patient does not meet these lab/diagnosis requirements for Monoferric, please order a different iron infusion. If Monoferric selected & patient does not qualify, the referring provider will be contacted.

**REQUIRED DIAGNOSIS CODE:** Monoferric is only available to patients with a diagnosis of Iron Deficiency Anemia (may have secondary diagnosis). Select PRIMARY diagnosis code from the list below.


**If NONE of the codes apply or if patient is pregnant, return to website to select a different iron option.**

"Low iron" or "low ferritin" are not acceptable diagnosis codes for Monoferric.

- ☐ D 50.0 IDA secondary to blood loss (chronic)
- ☐ D 50.1 Sideropenic dysphagia
- ☐ D 50.8 Other IDAs
- ☐ D 50.9 IDA, unspecified
- ☐ D 63.0 Anemia in neoplastic disease (code neoplasm first, confirm iron deficiency)
- ☐ D 63.1 Anemia in chronic kidney disease (code CKD stage first, confirm iron deficiency)
- ☐ D 63.8 Anemia in other chronic diseases classified elsewhere (code underlying disease first, confirm iron deficiency)
- ☐ D 64.81 Antineoplastic chemotherapy-induced anemia (confirm iron deficiency)

If applicable, select SECONDARY diagnosis code from list below:

- ☐ E 83.10 Iron metabolism
- ☐ K 50.0- K 50.919 Crohn's disease (regional enteritis)
- ☐ K 51.0-K 51.919 Ulcerative colitis
- ☐ K 90.0 Celiac disease
- ☐ K 90.4 Malabsorption due to intolerance not elsewhere classified
- ☐ K 90.9 Intestinal malabsorption unspecified
- ☐ N 18.1- N 18.9 Chronic kidney disease, CKD stage \_\_\_\_\_
- ☐ N 92.0 Excessive and frequent menstruation with regular cycle
- ☐ N 92.5 Other specified irregular menstruation
- ☐ N 92.6 Irregular menstruation, unspecified
- ☐ T 45.4X5A Adverse effect of iron and its compounds, initial encounter
- ☐ T 45.4X5D Adverse effect of iron and its compounds, secondary encounter
- ☐ T 45.4X5S Adverse effect of iron and its compounds, sequela encounter
- ☐ T 50.905A Adverse effect of unspecified drugs, medicaments and biological substances, initial encounter

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**Optional Pre-Medications:** Consider ordering pre-medications for patients with asthma, auto-inflammatory arthritis, or more than one hypersensitivity drug reaction (not intolerance). Give 30 minutes prior to infusion.

- ☐ MethylPREDNISolone sodium succinate (SOLUMEDROL) 62.5 mg/mL injection 125 mg, IV, every visit.
- ☐ Famotidine (PEPCID) injection 20 mg, IV, every visit. Dilute 2 mL of famotidine with 8 mL of normal saline to a final concentration of 2 mg/mL. Administer ordered dose over a period of at least 2 minutes.

**MEDICATION:**

- ✓ **Ferric Derisomaltose (MONOFERRIC)** in sodium chloride 0.9% 100ml IVPB. Infuse over 20 minutes. Give 1,000 mg if patient weighs 50 kg or more. Give 20 mg/kg if patient weighs less than 50 kg. This is a one time dose. **Accurate weight must be listed at the top of this form.**

**Standard included Nursing Orders:**

- ✓ Vital signs per clinic routine.
- ✓ Insert peripheral IV if no iv access.
- ✓ Sodium chloride 0.9% (NS) bolus 250 ml, Flush before and after IV medication(s) and as needed with NS.
- ✓ May use/access CVC line and give 500 units (5ml) heparin injection for central line care.
- ✓ Monitor patient for 30 minutes to assess for any post-infusion reaction.

**HYPERSENSITIVITY INFUSION REACTION ORDERS**

**MILD REACTION (aka fishbane reaction):** Slight chest tightness, Transient facial flushing, Headache, Nausea/diarrhea, Myalgia/arthritis/lumbar pain, Metallic taste, Increased anxiety, Itchiness.


1. Stop iron infusion for 15 min or longer and observe, immediately alert supervising provider.
2. Obtain vital signs (BP, pulse, respiratory rate, O2 saturation).
3. Watch for symptom progression or resolution.
4. Consider oxygen for hypoxia.
5. If unstable or symptoms worsen in 5-10 min, treat as a moderate-to-severe reaction.
6. If the patient remains stable after 15 min of total observation, consider completing iron infusion at less than 50% of the previous rate.
7. Observe for 1 hour after infusion and document reaction.

**MODERATE REACTION:** Transient cough, Flushing, Chest tightness, Nausea, Shortness of breath, Urticaria, Hypotension, Tachycardia.

1. Stop iron infusion, immediately alert supervising provider.
2. Obtain vital signs (BP, pulse, respiration rate, O2 saturation).
3. Watch for symptom progression or resolution.
4. Consider oxygen for hypoxia.
5. Administer cetirizine or loratadine and famotidine.
6. Consider volume load (e.g., 500-mL normal saline).
7. Consider IV corticosteroid (e.g., methylPREDNISolone).
8. If unstable or symptoms worsen, treat as a severe reaction.
9. Rechallenge or resume current iron infusion at the discretion of supervising provider.
10. Observe for 1-4 hours after infusion and document reaction.

**SEVERE or ANAPHYLAXIS REACTION:** Hypotension, Wheezing, Stridor, Periorbital edema, Arrhythmia/cardiovascular collapse, Unconscious or nonresponsive, Respiratory arrest.

1. Stop iron infusion, immediately alert supervising provider.
2. Initiate immediate rapid response, Code Blue protocol.
3. Administer cetirizine or loratadine and famotidine, if not already administered.
4. Administer EPINEPHrine, corticosteroids, vasopressors, and albuterol Code Blue response medications as indicated.
5. If unstable or symptoms worsen, transfer to intensive care unit.
6. Rechallenge or resume current iron infusion at the discretion of supervising provider.

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7. Observe for 4-24 hours after infusion attempt.

**MEDICATIONS:**

- Acetaminophen (TYLENOL) tablet 650 mg, Oral, EVERY 4 HOURS PRN, Mild pain, headaches, discomfort, mild reaction per provider instruction.
- Cetirizine (Zyrtec) tablet 10 mg, Oral, ONCE PRN, Moderate or severe reaction per provider instruction, for one dose.
- Methylprednisolone sodium succinate (Solu-Medrol) 62.5mg/ml injection, 125 mg, Intravenous, ONCE PRN, Moderate or severe reaction per provider instruction. For 1 dose. Mix with 2 mL provided diluent to make 62.5 mg/mL.
- Famotidine (Pepcid) injection 20 mg, Intravenous, ONCE PRN, Moderate or severe reaction per provider instruction. Dilute 2 mL of famotidine with 8 mL of normal saline to a final concentration of 2 mg/mL. Administer ordered dose over a period of at least 2 minutes.
- Albuterol 90 mcg/puff inhaler 2 puff, Inhalation, ONCE PRN, Severe reaction per provider instruction. For 1 dose. Shake well. Use with spacer.
- Start oxygen. For moderate reaction: Start 2 liters O2 per nasal cannula as needed for SpO2 less than 93% per provider instruction. For severe reaction: Start continuous pulse oximetry. Administer 6 to 8 liters per minute (LPM) via face mask, or up to 100% oxygen to maintain oxygen saturation greater than 90% per provider instruction.
- EPINEPHRINE 1 mg/mL injection 0.3 mg. Intramuscular, EVERY 5 MIN PRN, Severe or anaphylaxis per provider instruction. For 3 doses. Administer in the anterior lateral thigh using 1 - 1.5-inch needle for airway obstruction symptoms and/or hypotension.
- Sodium chloride 0.9% (NS) infusion 500mL. At 500 mL/hr, Intravenous, PRN, Moderate or severe reaction per provider instruction.

**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.

**My physician license Number is #** \_\_\_\_\_ **and I am acting within my scope of practice and authorized by law to order infusion of the medications and blood products described above for the patient identified on this form.**

**Provider's printed name:** \_\_\_\_\_

**Provider's signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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**Please complete the following intake questions.**

**Mobility status**

- ☐ Independent (no mobility devices used)
  - ☐ Uses assistive device (walker, cane)
  - ☐ Uses a wheelchair, but can transfer with minimal or no assistance
  - ☐ Moderate to maximum assistance with mobility, explain: \_\_\_\_\_
- \*Clinic location will reach out if unable to accommodate mobility assistance needs.

**Bariatric needs**

- ☐ Yes, briefly describe \_\_\_\_\_
- ☐ No

**Transportation concerns**

- ☐ Yes, briefly describe \_\_\_\_\_
- ☐ No

**Interpreter Service required**

- ☐ Yes, language \_\_\_\_\_
- ☐ No

**Outpatient Infusion Services Intake Team:**

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

- |  |   |
|--|---|
| <input type="checkbox"/> <b>PORTLAND</b>         | See Location Specific order form on Providence OPI website. |
| <input type="checkbox"/> <b>WILLAMETTE FALLS</b> | See Location Specific order form on Providence OPI website. |
| <input type="checkbox"/> <b>MEDFORD</b>          | Phone- <b>541-732-7000</b> Fax- <b>541-732-3939</b>         |
| <input type="checkbox"/> <b>HOOD RIVER</b>       | Phone- <b>541-387-6445</b> Call for fax #                   |
| <input type="checkbox"/> <b>SEASIDE</b>          | Phone- <b>503-717-7650</b> Fax- <b>503-470-3146</b>         |
| <input type="checkbox"/> <b>NEWBERG</b>          | See Location Specific order form on Providence OPI website. |