

 PROVIDENCE Health & Services ADULT AMBULATORY INFUSION ORDER 11/2025 IRON DEXTRAN (INFED) Infusion For Medford & Seaside ONLY	NAME: BIRTHDATE: INSURANCE: PROVIDER NAME: CLINIC NAME and Phone number: <div style="text-align: right;">Patient identification</div>
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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: _____ Diagnosis Code: _____
 Treatment Start Date: _____

****If treatment not started within 90 days, new orders with updated date/signature will be required.****

- 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**.
- 3) Send a copy of related lab results if not available in Epic, **results must be within the last 60 days**.

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.

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:

- ✓ **Iron Dextran (INFED)**
- ✓ **Test dose:** Iron dextran (INFED) 25 mg, intravenous injection. Administer IV push over at least 30 seconds or more. Observe patient for hypersensitivity reaction for 10 minutes before giving the subsequent dose.
- ✓ **Treatment dose:** Iron dextran (INFED) 975 mg in sodium chloride 0.9% 250 mL IVPB, Intravenous. Infuse over 1 hour. Administer 10 minutes after 25 mg test dose if no reaction.
- ✓ *If the patient has tolerated Iron Dextran (INFED) in the past and records are readily available for review, NO test dose will be given, and the full 1000 mg will be given over 1 hour instead.*

Standard included Nursing Orders:

- ✓ Vital signs per clinic routine.
- ✓ Monitor patient for 30 minutes post infusion.
- ✓ 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.

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.

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