FERUMOXYTOL (FERAHEME®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

option care health™

Patient Name:			**Date of Birth:**	
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Ferumoxytol (Feraheme®) Prescription

Ferumoxytol (Feraheme®)

☐ Infuse 510 mg IV over at least 15 minutes on Day 1. May repeat dose after _____ days.
☐ Infuse 1020 mg IV over 30 minutes as a single dose.

☐ Other: _____

Dispense QS sufficient for each dose.

Refills: _____

Ancillary Orders

Anaphylaxis Kit

➔ Required per Option Care Health policy – please complete Anaphylaxis Physician Order (FR-PC-036) provided.

Pre-Medication Orders

☐ Acetaminophen 650 mg PO 30 min before infusion. Patient may use own supply or patient may decline.
☐ Cetirizine 10 mg PO 30 min before infusion. Patient may use own supply or patient may decline.
☐ Diphenhydramine 25 mg PO 30 min before infusion. Patient may use own supply or patient may decline.

☐ Other: _____

IV Flush Orders

☐	Peripheral:	NS 2 to 3 mL pre-/post-use.
☐	PICC and Central Tunneled/Non-Tunneled:	NS 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin ☐ (10 unit/mL) 5 mL or ☐ (100 unit/mL) 3 mL every post-use. For maintenance, heparin (10 unit/mL) 5 mL) or (100 unit/mL) 3 mL every 24 hr.
☐	Implanted Port:	NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

ANAPHYLAXIS PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

option care health

Patient Name:	**Date of Birth:**	
Address:	**Weight:**	☐ lbs ☐ kg

Anaphylaxis Kit Components

Adults & Pediatrics > 30 kg	Diphenhydramine 1 mL (50 mg/mL) vial #1	25 mg	Slow IV push (if line patent) or IM; may repeat x 1 in 15 min PRN if no improvement
	Epinephrine 1 mL ampule/vial (1 mg/mL) #2	0.3 mg	SQ x 1 dose & repeat x 1 in 5 to 15 min PRN
	or		**or**
	*Epinephrine 0.3 mg auto-injector 2-pack kit #1		IM x 1 dose & may repeat x 1 in 5 to 15 min PRN
	Normal saline 500 mL bag #1	500 mL	KVO rate PRN anaphylaxis or over 2 to 4 hr PRN headache rated > 5 on pain scale
Pediatrics 15 to 30 kg	Diphenhydramine 1 mL (50 mg/mL) vial #1	1.25 mg/kg	Slow IV push (if line patent) or IM; may repeat x 1 in 15 min PRN if no improvement
	Epinephrine 1 mL ampule/vial (1 mg/mL) #2	0.15 mg	SQ x 1 dose & repeat x 1 in 5 to 15 min PRN
	or		**or**
	*Epinephrine 0.15 mg auto-injector 2-pack kit #1		IM x 1 dose & may repeat x 1 in 5 to 15 min PRN
	Normal saline 250 mL bag #1	250 mL	KVO rate PRN anaphylaxis or over 2 to 4 hr PRN headache rated > 5 on pain scale
Pediatrics < 15 kg	Diphenhydramine 1 mL (50 mg/mL) vial #1	1.25 mg/kg	Slow IV push (if line patent) or IM; may repeat x 1 in 15 min PRN if no improvement
	Epinephrine 1 mL ampule/vial (1 mg/mL) #2	0.01 mg/kg	SQ or IM x 1 dose & repeat x 1 in 5 to 15 min PRN
	Normal saline 250 mL bag #1	250 mL	KVO rate PRN anaphylaxis

Dispense supplies necessary to administer aforementioned medications, including syringes and needles.
*For subcutaneous immune globulin patients, only epinephrine auto-injector 2-pack kits will be dispensed.

Management of Anaphylaxis

General Anaphylaxis

1. ***STOP*** infusion.
2. Administer emergency meds as ordered.
3. Administer epinephrine as above and repeat dose if necessary.
4. Administer injectable diphenhydramine as above or orally per treatment guidelines.
5. If IV line is in place, infuse normal saline.
6. Initiate CPR (if needed).
7. Call EMS (activate the emergency medical system).
8. Monitor vital signs – elevate legs if hypotensive.
9. Notify prescriber and Option Care Health Director of Nursing and pharmacist.

Subcutaneous Immune Globulin Anaphylaxis – *For **SEVERE** reactions such as wheezing, difficulty in breathing, or swelling of eye lids, lips, or throat.*

1. ***STOP*** the infusion of the medication immediately and remove the needles from the skin.
2. Call 911.
3. Administer epinephrine for one dose as above, repeat dose if necessary.
4. Notify prescriber and Option Care Health Director of Nursing or pharmacist.

Intravenous Immune Globulin Anaphylaxis – *If nurse is present in the home, for **SEVERE** reactions including angioedema, wheezing, difficulty in breathing, or swelling of eye lids, lips, or throat.*

1. ***STOP*** the infusion of the medication immediately. Completely remove the source of the infusate while maintaining venous access.
2. Contact or have caregiver call 911.
3. Administer epinephrine as above and may repeat dose if necessary.
4. Administer *injectable* diphenhydramine (Benadryl®) as above.
5. Monitor and document patient's vital signs, including mental status. If hypotensive, place the patient in supine position with lower extremities elevated or in Trendelenburg position. If breathing difficulty, tilt the patient's head or thrust jaw to relieve airway obstruction.
6. Maintain IV line with normal saline (sodium chloride 0.9%) as above to keep line open until the arrival of a paramedic or ambulance.
7. Contact the prescriber and Option Care Health Director of Nursing or pharmacist.
8. If cardiopulmonary arrest occurs, begin CPR.
9. Monitor and document vital signs every 2 minutes until stable, then every 15 minutes as needed.
10. Remain with patient until paramedics arrive.

When appropriate, nurse shall instruct patient/caregiver about the signs/symptoms of allergic, anaphylactic, and adverse reactions along with the proper use of kit medications. This physician order shall be recognized for the patient's period of treatment and/or up to one year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: **Date:**

Prescriber Information

Prescriber Name:	**NPI:**

