EMORY HEALTHCARE

PHYSICIAN'S ORDERS

Therapy: Ferric Carboxymaltose (Injectafer®)

[Place patient sticker here]

Name: _____
MRN: _____
DOB: _____

Today's Date _____ Time _____

Diagnosis: ☐ Iron Deficiency Anemia ☐ Other: _____

Age: _____ Height (cm): _____ Weight (kg): _____ BSA (m^2): _____

ALLERGIES/Sensitivities: ☐ NKDA or ☐ _____

Start Date (at least 1 wk from today)**:** _____ ☐ **Urgent (Call Infusion Center)**

Treatment Department: ☒ EHW OP Infusion

Appointment Requests: *Tolerance:* ☒ *Use default, for chronic treatments order valid for 1 year*

☐ Appointment Request – 2 hours — Every 7 days

Labs: ☒ *Once*

☐ Phosphorus
☐ CBC & Diff
☐ TIBC
☐ Ferritin

Pre-Medications: ☒ *Order will be done as per appointment frequency*
☒ *Instructions: Give at treatment start time prior to infusion of medication*

☐ Acetaminophen tablet 650 mg, oral, Once

☐ DiphenhydrAMINE 25mg, once (choose one) ☐ tablet, Oral ☐ injection, IV

☐ MethylPREDNISolone, injection, 125 mg IV, once

☐ Prochlorperazine, tablet 10 mg, PO, once

☐ Other: _____

☐ Other: _____

Observation Orders: ☒ *Order will be done as per appointment frequency*

☒ Observe/Monitor patient for signs/symptoms of hypersensitivity reaching during infusion and for 30 minutes following each infusion

All information provided on this form & calculations have been independently confirmed & recalculated as indicated by signature(s) below

Licensed Medical Professional		**Attending Physician**	
Print Name:		Print Name:	
Signature		Signature	
Date		Date	
Contact #		Contact #	

[Place patient sticker here]

Name: _____
MRN: _____
DOB: _____

Therapy: Please time for **60 minutes** after treatment start time

☒ Ferric Carboxymaltose (Injectafer®)

☐ **≥ 50 kg: 750 mg** IV in 250 mL NS infused over at least 20 minutes for
- ☐ 1 Dose
- ☐ 2 Doses

☐ **< 50 kg: _____ mg (15 mg/kg)** IV in 250 mL NS infused over at least 20 minutes for
- ☐ 1 Dose
- ☐ 2 Doses

☒ Subsequent doses MUST be given at least 7 days from the last dose

Emergency Medications

☒ *Order will be done as per appointment frequency*

☒ Hypersensitivity reaction protocol
Protocol Document: https://emory.ellucid.com/documents/view/15307/15641

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Licensed Medical Professional		**Attending Physician**	
Print Name:		Print Name:	
Signature		Signature	
Date		Date	
Contact #		Contact #	