CHILDREN'S HEALTH

Patient Name: _____

Date of Birth: _____

PHYO
CMC85044-001NS Rev. 2/2021

Ferric Carboxymaltose (INJECTAFER) Infusion Therapy Plan

Baseline Patient Demographic

To be completed by the ordering provider.

Diagnosis: _____ Height: _____cm Weight: _____kg Body Surface Area: _____ (m^2)

☐ NKDA - No Known Drug Allergies ☐ Allergies: _____

_____

Therapy Plan orders extend over time (several visits) including recurring treatment.

Please specify the following regarding the entire course of therapy:

Duration of treatment: _____ weeks _____ months _____ unknown

Treatment should begin: ☐ as soon as possible (within a week) ☐ within the month

****Plans must be reviewed / re-ordered at least annually. ****

ORDERS TO BE COMPLETED FOR EACH THERAPY

ADMIT ORDERS

☑ **Height and weight**

☑ **Vital signs**

Hypotension Defined Admit

☐ **Nursing communication**

Prior to starting infusion, please determine the patient's threshold for hypotension as defined by the following parameters. This information will be needed in the event of an infusion reaction occurring.
Hypotension is defined as follows:
1 month to 1 year - systolic blood pressure (SBP) less than 70
1 year to 11 years - systolic blood pressure (SBP) less than 70 + (2 x age in years)
11 years to 17 years - systolic blood pressure (SBP) less than 90
OR any age - systolic blood pressure (SBP) drop of more than 30% from baseline.
Baseline systolic blood pressure (SBP) x 0.7 = value below defined as hypotension.

NURSING ORDERS

Please select all appropriate therapy

IV START NURSING ORDERS

☐ **Insert peripheral IV / Access IVAD**

Place PIV if needed or access IVAD if available

☐ **lidocaine 1% BUFFERED (J-TIP LIDOCAINE)**

0.2 mL, INTRADERMAL, PRN

☐ when immediate procedure needed ☐ when procedure will take about 1 minute ☐ patient / family preference for procedure

Administration Instructions: NOTE: Do not use this medication in patients with bleeding disorders, platelets ≤ 20,000, or in patients taking anticoagulants, when accessing implanted ports or using a vein that will be utilized for chemotherapy administration, nor for pre-term infants or neonates.

☐ **lidocaine - prilocaine (EMLA) cream**

TOPICAL, PRN

☐ when more than 60 minutes are available before procedure ☐ when procedure will take more than 1 hour

☐ patient / family preference for procedure

Administration Instructions: NOTE: In children < 3 months of age, or < 5 kg in weight, maximum application time is 1 hour.

Key: cm = centimeter; IV = intravenous; IVAD = implantable venous access device; kg = kilogram; m² = square meters; mg = milligram; mL = milliliter; mL / hr = milliliters per hour; mm = millimeter; mOsm / L = milliosmole per liter; NKDA = no known drug allergies; NS = normal saline; pH = hydrogen ion concentration; PIV = peripheral intravenous; PRN = as needed; SBP = systolic blood pressure

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NURSING ORDERS, CONTINUED

☐ **lidocaine - tetracaine (SYNERA) patch**
TOPICAL, PRN
☐ when 20 - 30 minutes are available before procedure ☐ when procedure will take more than 1 hour
☐ when anticipated pain is less than 5 mm from skin surface ☐ patient / family preference for procedure

☐ **lidocaine with transparent dressing 4% kit**
TOPICAL, PRN
☐ when 20 - 30 minutes are available before procedure ☐ when procedure will take more than 1 hour
☐ patient / family preference for procedure

☐ **Heparin flush**

heparin flush
10 - 50 units, INTRAVENOUS, PRN, IV line flush. Per protocol, heparin should not be used to flush peripheral IVs. This heparin flush should be used with all central lines including IVADs, with the exception of de - accessing the IVAD.

heparin flush
100 - 300 units, INTRAVENOUS, PRN, IV line flush. Per protocol, heparin should not be used to flush peripheral IVs. For use only when de - accessing IVADs.

☐ **Sodium chloride flush**

Sodium chloride flush 0.9% injection
1 - 20 mL, INTRAVENOUS, PRN, IV line flush

Sodium chloride - preserative free 0.9% injection
1 - 30 mL, INTRAVENOUS, PRN, IV line flush

PRE-PROCEDURE LABS

☑ **Complete Blood Count with Differential** **INTERVAL: Every 6 weeks** **DEFER UNTIL: _____** **DURATION: For 2 treatments**
Unit collect, baseline labs before 1st infusion and repeat labs in 6 weeks.

☑ **Transferrin** **INTERVAL: Every 6 weeks** **DEFER UNTIL: _____** **DURATION: For 2 treatments**
Unit collect, baseline labs before 1st infusion and repeat labs in 6 weeks.

☑ **Total Iron Binding Capacity** **INTERVAL: Every 6 weeks** **DEFER UNTIL: _____** **DURATION: For 2 treatments**
Unit collect, baseline labs before 1st infusion and repeat labs in 6 weeks.

☑ **Reticulocytes** **INTERVAL: Every 6 weeks** **DEFER UNTIL: _____** **DURATION: For 2 treatments**
Unit collect, baseline labs before 1st infusion and repeat labs in 6 weeks.

☑ **Ferritin** **INTERVAL: Every 6 weeks** **DEFER UNTIL: _____** **DURATION: For 2 treatments**
Unit collect, baseline labs before 1st infusion and repeat labs in 6 weeks.

☑ **Retic Hemoglobin equivalent-Rectic-He** **INTERVAL: Every 6 weeks** **DEFER UNTIL: _____** **DURATION: For 2 treatments**
Unit collect, baseline labs before 1st infusion and repeat labs in 6 weeks.

INTRA-PROCEDURE

☑ **Vital signs**
Baseline vital signs (blood pressure, pulse, respiration, and temperature), then monitor vitals 5 minutes after initiation of infusion, at completion of infusion, then every 15 minutes until 30 minutes after infusion completed.

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INTRA-PROCEDURE, CONTINUED

☑ **Perform pain assessment**
Assess pain prior to start of ferric carboxymaltose infusion.

☑ **Physician communication order**

Please enter the dose of ferric carboxymaltose in 'mg' to facilitate prior authorization requirements.
< 50 kg: 15 mg / kg (Maximum of 750 mg)
>/= 50 kg: 750 mg
This mixture record is defaulted to a base of 100 mL sodium chloride 0.9%. Please indicate the desired volume if it is other than 100 mL:
_____ mL

☑ **ferric carboxymaltose in sodium chloride 0.9% 100 mL infusion**
INTERVAL: 1 time a week DEFER UNTIL: _____ DURATION: For 2 treatments
INTRAVENOUS, at 400 mL / hour, ONCE, administer over 15 minutes. Dose must be separated by at least 7 days. Administer over a minimum of 15 minutes. Monitor vital signs (including blood pressure); signs and symptoms of hypersensitivity (monitor for ≥ 30 minutes following the end of administration and until clinically stable); monitor infusion site for extravasation.
Dose: _____mL

Therapy Appointment Request
Please select department for the therapy appointment request:

Expires in 365 days

☐ Dallas Special Procedures ☐ Plano Infusion Center ☐ Dallas Allergy ☐ Dallas Transplant ☐ Dallas Neurology

EMERGENCY MEDICATIONS

☑ **Nursing communication**

1. Hives or cutaneous reaction only – no other system involvement
PATIENT IS HAVING A DRUG REACTION:
   - **a.** Stop the infusion
   - **b.** Give diphenhydramine as ordered
   - **c.** Check heart rate, respiratory rate and blood pressure every 5 minutes until further orders from provider.
   - **d.** Connect patient to monitor (cardiac / apnea, blood pressure and oxygen saturation) if not already on one
   - **e.** Notify provider for further orders

2. Hives or cutaneous reaction plus one other system, i.e. abdominal cramping, vomiting, hypotension, altered mental status, respiratory distress, mouth / tongue swelling
PATIENT IS HAVING ANAPHYLAXIS:
   - **a.** Stop the infusion
   - **b.** Call code – do not wait to give epinephrine
   - **c.** Give epinephrine as ordered
   - **d.** Notify provider
   - **e.** Check heart rate, respiratory rate and blood pressure every 5 minutes until the code team arrives.
   - **f.** Connect patient to monitor (cardiac / apnea, blood pressure and oxygen saturation), if not already on one.
   - **g.** Give diphenhydramine once as needed for hives
   - **h.** May repeat epinephrine every 5 minutes x 2 doses for persistent hypotension and respiratory distress with desaturation until code team arrives.
   - **i.** May give albuterol as ordered for wheezing with oxygen saturation stable while waiting for code team, continue to monitor oxygen saturation.

   Hypotension is defined as follows:
   1 month to 1 year – systolic blood pressure (SBP) less than 70
   1 year to 11 years – systolic blood pressure (SBP) less than 70 + (2 x age in years)
   11 years to 17 years – systolic blood pressure (SPB) less than 90
   OR any age – systolic blood pressure (SPB) drop more than 30% from baseline.
   Baseline systolic blood pressure x 0.7 = value below defined as hypotension.

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EMERGENCY MEDICATIONS, CONTINUED

☐ **EPINEPHrine Injection Orderable For Therapy Plan (AMPULE / EPI - PEN JR. / EPI - PEN) 0.01 mg / kg**

0.01 mg / kg, INTRAMUSCULAR, EVERY 5 MINUTES PRN, for anaphylaxis and may be repeated for persistent hypotension and respiratory distress with desaturation until the code team arrives, for 3 doses
Use caution with PIV administration. This solution has a pH < 5, or a pH > 9, or an osmolality > 600 mOsm / L.
Dose: _____

☐ **Cardio / Respiratory Monitoring**
Rationale for Monitoring: High risk patient (please specify risk)
- ☐ Clinically significant cardiac anomalies or dysrhythmias
- ☐ Recent acute life-threatening event
- ☐ Unexplained or acutely abnormal vital signs
- ☐ Artificial airway (stent, tracheostomy, oral airway)
- ☐ Acute, fluctuating or consistent oxygen requirements

Monitor Parameters (select all that apply): ☐ Heart rate ☐ Oxygen saturation ☐ Respiratory rate
Telemetry Required: ☐ Yes ☐ No

☐ **diphenhydrAMINE injection**

1 mg / kg, INTRAVENOUS, ONCE PRN, for hives or cutaneous reaction, for 1 dose maximum dose = 50 mg per dose, 300 mg per day.
Dose: _____

☐ **Albuterol for aerosol**

0.25 mg / kg., INHALATION ONCE PRN, for wheezing, but oxygen saturations stable while waiting for code team, continue to monitor oxygen saturation for 1 dose
Dose: _____

POST - PROCEDURE

☑ **Nursing communication**

Flush PIV or IVAD with 20 mL 0.9% sodium chloride at the completion of the infusion.
Flush IVAD with saline and heparin flush per protocol prior to de-accessing IVAD.
Discontinue PIV prior to discharge on the last day of infusion.

☑ **Sodium chloride 0.9% infusion**

INTRAVENOUS, at 0 -25 mL / hr, ONCE, for 1 dose
Dose: _____

Signature of Provider	Credentials (circle one): MD DO	Date	Time

Printed Name of Provider

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