BioPlus® Infusion

Fax your completed order to 877-734-1157

Patient Name: _____ DOB: ___/___/_____ Date of Last Infusion: ___/___/_____
Height_____ Weight_____
Infusion Location: (state and site) _____

Feraheme® (ferumoxytol) Infusion Orders

Diagnoses- please provide ICD-10 and description in spaces provided		
BOTH PRIMARY AND SECONDARY DIAGNOSES ARE REQUIRED		
_____ Iron Deficiency Anemia (ICD-10)	AND	_____ _____ (ICD-10) Description of underlying disease
_____ Chronic Kidney Disease: Stage _____ (ICD-10)	AND	☐ D63.1 Anemia in CKD
_____ _____ (ICD-10) Description of underlying disease	AND	☐ D63.8 Anemia in Chronic Disease
Other: (BOTH primary and secondary dx including ICD-10 codes): _____		

Hold infusion and notify provider for:
- Hypotension (SBP less than 90 mmHg).
- History of allergy to other IV iron product

- Place patient in reclined or semi-reclined position and record vital signs before, after and every 30mins
- Instruct patient to complete follow-up lab testing as ordered below
- If related reaction occurs, stop infusion and initiate Hypersensitivity Reaction Management Protocol

Pre-medications: (consider in presence of risk factors for hypersensitivity reaction i.e. multiple drug allergies).
•Solu-Medrol 125 mg IVP once 30 minutes prior to infusion •Other:_____

Dosing:

☐ Administer TWO (2) DOSES of Feraheme 510 mg separated by 3-8 days Dilute in 100 ml 0.9% sodium chloride and infuse over 15-30 minutes
☐ Administer SINGLE DOSE of Feraheme 510 mg Dilute in 100 ml 0.9% sodium chloride and infuse over 15-30 minutes

Observation Period Mandatory for all patients every visit. If patient refuses to stay, ROR form may be signed to waive observation period after _____ infusions:
- Monitor patient for hypersensitivity reaction for a period of 30 minutes following each infusion
- Record vital signs prior to discharge

Follow-up Lab Orders: At least one month following last iron infusion, draw the following:
☐ CBC w/diff, ferritin, transferrin saturation, TIBC
(RN: Provide patient with order and fill in date: Draw on or after _____/_____/_____)

Provider Name (print)_____ Date:_____
Provider Signature:_____ Time:_____