BioPlus® Infusion

**Fax your completed order to 877-734-1157**

Patient Name: _____ DOB: ___/___/_____

Date of Last Infusion: ___/___/_____ Height_____ Weight_____

Infusion Location: (state and site) _____

# Injectafer® (ferric carboxymaltose) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ Iron Deficiency Anemia (ICD-10)  _____ Chronic Kidney Disease: Stage ☐ 1 ☐ 2 ☐ 3 ☐ 4 (ICD-10)

_____ Other: _____ (ICD-10)  _____ Other: _____ (ICD-10)

Hold infusion and notify provider for:

- Hypertension

- Record vital signs before and after infusion, or at least every 30 minutes
- Instruct patient to complete follow-up lab testing as ordered below
- IF infusion-related reaction occurs, stop infusion and initiate Hypersensitivity Reaction Management Protocol as clinically indicated

☐ Administer TWO (2) DOSES of Injectafer 750 mg separated by at least 7 days.
Dilute in 250 ml 0.9% sodium chloride and infuse over 30 minutes.

☐ Administer SINGLE DOSE of Injectafer 1000mg
Dilute in 250 ml 0.9% sodium chloride and infuse over 30 minutes

For patients weighing less than 50 kg (110 lbs):

☐ Administer Injectafer 15 mg/kg x _____kg = _____mg. (max of 1000mg)
Dilute in 250 ml 0.9% sodium chloride and infuse over 30 minutes

☐ Frequency: Repeat dose in 7 days for _____doses

Observation Period:

- 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, phosphorus

RN: Fill in date and provide order to patient: Draw on or after _____/_____/_____

Fax results to provider at: _____ cc: _____

Additional Orders:

_____

_____

Provider Name (print)_____ Date:_____

Provider Signature: _____ Time: _____