Novella Infusion

Patient Name:
DOB:
Date of Last Infusion
Insurance:

Clinic Location:
Merrimack, NH ☐
Concord, NH ☐

Injectafer® (ferric carboxymaltose) Infusion Orders

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

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

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

Hold infusion and notify provider for:

- Signs or symptoms of illness or active infection
- 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 750 mg**.
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**. Dilute in 250 ml 0.9% sodium chloride and infuse over 30 minutes.

☐ Repeat dose in 7 days

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: 603-570-1470**

Additional Orders:

Provider name (print): _____ Date:_____

Provider signature: _____ Time: _____

Revised 3/6/19. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.