Novella Infusion

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	c D63.1 Anemia in CKD
_____ _____ (ICD-10) Description of underlying disease	AND	c 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 <u>one month</u> 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: _____

Order updated 4/13/23