Atrium Health Infusion Centers
Phone: 704-468-3400 **Fax:** 704-468-3401

Injectafer Infusion Order (Revised 7/14/21)

Instructions to Provider: All orders with ☒ will be placed unless otherwise noted. Please fax completed order, along with referral form to desired location.

Required Lab Results: CBC within the last 6 months (If outside of Atrium, please fax with order, required prior to scheduling)

Infusion Therapy:

☐ Injectafer (ferric carboxymaltose) **_750__** mg IV over 20 minutes at week 0 and week 2

☐ Injectafer (ferric carboxymaltose) **_15_**mg/kg IV over 20 minutes at week 0 and week 2 (for weight less than 50kg)

ICD 10 code: _____

Pre-Meds:

Administer 30 minutes prior to Injectafer: ☐ No Pre-meds Needed

☐ Acetaminophen _____ mg PO x 1

☐ Benadryl _____ mg IV x 1

☐Famotidine _____ mg IV x 1

☐ SoluMedrol _____ mg IV x 1

PRN Medications:

☐Zofran **4**mg IV every 3 hours PRN nausea/vomiting

☐Ibuprofen **800**mg PO every 8 hours PRN pain

Additional Orders:

_____

Special Instructions:

- Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.
- If Benadryl is administered, the patient may not drive home. They must have a driver.

Infusion Monitoring:

- Obtain vital signs pre- and post-infusion. Obtain vital signs PRN during infusion.
- Monitor patients for signs and symptoms of hypersensitivity during and after Injectafer administration for at least 30 minutes and until clinically stable following completion of the infusion.

Provider Name: _____

Provider Signature: _____

Date: _____ (Order valid for 1 year)

Patient Name:

DOB:

MRN:

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