



# METRO INFUSION CENTER

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Diagnosis/Code: \_\_\_\_\_ / \_\_\_\_\_

## Reblozyl (luspatercept-aamt)

**Dose calculation: Mg/Kg dosing****Wt used for dosing: \_\_\_\_\_ kg** Dose should be based on current day of injection weight and thus changes each visit (can be rounded to nearest vial size available at the visit) Use weight on order unless weight changes more than 10%**Dosing Guidelines/Parameters: Provider must select hold parameters that will trigger a call from the Infusion Staff** CBC will be done prior to each dose Dosing based on most recent hemoglobin and reduction of RBC transfusion (Review of labs and RBC transfusion need is the responsibility of the referring provider office and must be sent with the clearance form attached to this order to guide treatment). Hold dose if hemoglobin is greater than or equal to 11.5g/dl in the absence of a recent transfusion. (If an RBC transfusion occurred prior to dosing, use the pretransfusion hemoglobin for dose evaluation)

### Treatment Orders:

DRUG	DOSE	ROUTE	DAYS TO BE GIVEN
<input type="checkbox"/> Reblozyl (luspatercept-aamt)- <b>starting dose</b>	1mg/kg= _____mg	SQ	x1 dose then based on hemoglobin and transfusion need*
<input type="checkbox"/> Reblozyl (luspatercept-aamt) Current dose patient is on (if not on 1mg/kg) at time of transition to Metro Infusion Center	_____mg/kg= _____mg	SQ	X 1 dose then based on hemoglobin and transfusion need*
<input type="checkbox"/> Reblozyl (luspatercept-aamt) Fixed dose- no titration up will occur	_____mg/kg= _____mg	SQ	Every _____ weeks*

\*\*The Reblozyl clearance form should accompany the labs from the providers office

NOTE: Dose changes may require new insurance authorizations.

 Ok to give current dose level until new authorization obtained

Date of intended first treatment at Metro Infusion Center: \_\_\_\_\_

Subsequent treatment may be given +/- 2 days or as otherwise specified: \_\_\_\_\_

***This order is good for 1 year from the date ordered***

Other:

Call referring provider for:

Hypertension

Date:

Referring Provider: \_\_\_\_\_ Phone# \_\_\_\_\_

SIGNATURE REQUIRED

PRINTED NAME REQUIRED

Office Contact name/number: \_\_\_\_\_ / \_\_\_\_\_

All information in this order is strictly confidential and will become part of the patient's medical record. Contact us with questions at (877)448-3627. Send completed form and all documentation to confidential email:

[MICreferral@metroinfusioncenter.com](mailto:MICreferral@metroinfusioncenter.com) or fax to (866)507-1164



## Reblozyl (luspatercept-aamt) Clearance form

*To be completed by the office prior to EACH dose; accompanied by the CBC and signed by the provider to guide dosing based on hemoglobin and transfusion requirements as per PI*

CBC has been reviewed

Patient has had \_\_\_\_\_ transfusion in the last 6 weeks

### Dosing instructions

Hold treatment today as the hemoglobin rose greater than 2g/dl in the last 3 weeks or is greater than 11.5 before a transfusion  
(Follow up plan will be noted below in "additional comments")

Keep dose as per current order of \_\_\_\_\_mg SQ based on hemoglobin and transfusion requirements  
(previous order is still active and should be used for dosing)

Based on labs/transfusion needs, dose changed to \_\_\_\_\_mg SQ  
(This serves as the current order. This clearance form must be sent for guidance for next treatment)

**NOTE:** Dose changes may require new insurance authorizations.

Ok to give current dose level until new authorization obtained

Any additional comments:

Signature of provider: \_\_\_\_\_/Date: \_\_\_\_\_

All information in this order is strictly confidential and will become part of the patient's medical record. Contact us with questions at (877)448-3627. Send completed form and all documentation to confidential email:

[MICreferral@metroinfusioncenter.com](mailto:MICreferral@metroinfusioncenter.com) or fax to (866)507-1164