MIC METRO INFUSION CENTER

Reblozyl (luspatercept-aamt)

Name: _____
DOB:_____
Diagnosis/Code: _____/_____

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
☐ Reblozyl (luspatercept-aamt)- **starting dose**	1mg/kg=_____mg	SQ	Every Week Adjustments should be made based on hemoglobin and transfusion need***
☐ 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	☐Every Week ☐Every _____Week(s) Adjustments should be made based on hemoglobin and transfusion need***
☐ 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.comor fax to (866)507-1164

Updated 6/30/26

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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 every _____weeks(s) based on hemoglobin and transfusion requirements

(This serves as the current order. This clearance form must be sent for guidance for next treatment)

☐ Based on labs/transfusion needs, dose changed to _____mg SQ every _____week(s)

(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:_____

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