Iron Order Form | Monoferric & Venofer

Please fax the completed form to **1-866-640-1749**

PATIENT DETAILS			
NAME		**DATE OF BIRTH (DD/MM/YYYY)**	
PHONE		**EMAIL**	
ADDRESS		**HEALTH CARD NUMBER**	
EMERGENCY CONTACT NAME		**EMERGENCY CONTACT NUMBER**	

CLINICAL DETAILS					
DIAGNOSIS		**HEMOGLOBIN**	g/l	**FERRITIN**	ng/mL
WEIGHT (KG)		**ALLERGIES**			
Is patient pregnant, breastfeeding, or under the age of 18?		☐ No ☐ Yes → Please prescribe Venofer instead as Monoferric is not currently approved for use in pregnancy/lactation or patients under age 18 in Canada. Please note that Venofer should not be given to pregnant women in the first trimester.			
Has patient received IV iron previously?		☐ No ☐ Yes → Indicate if any reaction:			

PRESCRIPTION

☐ **MONOFERRIC** ☐ ***ONTARIO LU CODE 610***	☐ **VENOFER**
Simplified Monoferric Weight-Based Table Hb (g/L) / <50kg / 50-70kg / ≥70kg ≥100 / 500mg / 1000mg / 1500mg <100 / 500mg / 1500mg / 2000mg Doses that exceed the weight-based chart above, 20mg iron/kg body weight, or 1500mg, must be split into multiple doses separated by at least 7 days (Induction Dose). If the dose is not clearly specified, the product monograph administration guidelines will be followed.	Simplified Venofer Dosing Table Max Dose for Treatment Regime = 1000mg Max Daily Dose = 300mg
DOSE	**DOSING REGIMEN**
☐ 500mg ☐ 1000mg ☐ 1500mg ☐ 2000mg (induction) Total Number of Doses: _____ Interval: ☐ 2 months ☐ 3 months ☐ 6 months ☐ Other: _____	☐ 200mg IV every _____ week(s) for _____ doses ☐ 300mg IV every _____ week(s) for _____ doses ☐ Other: _____ mg IV every _____ week(s) for _____ doses

OTHER MEDICATIONS

If the patient has a HISTORY of reaction to any Iron products, give the following medication IMMEDIATELY prior to the infusion:

☐ Methylprednisolone 125mg IV x1
☐ Diphenhydramine 25-50 mg PO/IV
☐ Acetaminophen 650 mg PO
☐ Other:

☐ Our clinics follow a standardized protocol to manage reactions during our post-infusion. Please tick this box to indicate that you agree with the following protocol. If the patient has adverse reaction DURING/POST infusion, give:

☐ Hydrocortisone 100mg IV ☐ Methylprednisolone 125mg IV
☐ Diphenhydramine 25-50mg PO/IV ☐ Acetaminophen 650mg PO
☐ Dimenhydrinate Gravol© 25-50mg PO/IV

Current infusion reaction protocol includes the use of above medications according to nurse's assessment.

PRESCRIBER DETAILS

SRx will handle special authorization forms and apply an infusion fee at SRx Clinics. Patients receive a receipt for tax or health account purposes. Patients will be scheduled at an SRx Clinic within 7 days of payment. Prescribers will be notified if the patient cannot be reached. Post-infusion reports are provided. For Hospital Day Medicine appointments, patients receive home-delivered drugs to bring to their appointment. Bloodwork may be updated to meet clinic standards.

ADDRESS		**PHONE**		**FAX**	
PRESCRIBER NAME		**LICENSE NUMBER**			
PRESCRIBER SIGNATURE		**DATE (DD/MM/YYYY)**			

SRx CLINICS