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Document Title: Edmonton Monoferric Order Form Version No: 10

EDMONTON MONOFERRIC ORDER FORM

P: 587-454-2413 F: 587-454-0885

Patient information

Name:	DOB (dd/mm/yyyy):	Weight:	PHN:
Address:	Allergies:	Phone number:	Emergency contact number

Prescriber information

Name:	Office/Clinic	Phone number:	Fax number:

Clinical Information:

Is Patient Pregnant, Breastfeeding or under age 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.*

Diagnosis: _____Patient Hemoglobin: _____g/L Ferritin: _____

Has patient tried oral iron supplementation? ☐Yes ☐No Comments: _____

Has patient received IV iron previously and if so, was there a reaction? Details_____

Prescription:

Monoferric *(iron isomaltoside)* to be administered by IV Infusion as per product monograph

Simplified Monoferric Weight-Based Table

Hb (g/L)	Body Weight Under 50 kg	Body weight 50 kg up to 70 kg	Body weight 70 kg or more
At or Above 100	500 mg	1000 mg	1500 mg
Less than 100	500mg	1500 mg	2000 mg

**Doses greater than weight-based chart above, or exceeding 20mg iron/kg body weight, or exceeding 1500mg must be divided into multiple doses separated by at least 7 days (ie. Induction Dose). If dose is not clearly stated on this form, administration guidelines as per product monograph will be followed.*

Dose: ☐ 500mg ☐ 1000mg ☐ 1500mg ☐ 2000mg (Induction Dose)

Total Number of doses: _____ Interval: ☐2 Months ☐ 3 Months ☐ 6 Months ☐ Other: _____

Note: Prescribers are responsible for ordering and monitoring patient blood work as well as notifying infusion clinic as soon as patient no longer requires above treatment.

If the patient has a history of reaction to any iron products: Give:	**If the patient has adverse reaction DURING/POST infusion: Give:**
☐ Methylprednisolone 125mg IV	☐ Hydrocortisone 100mg IV ** **and/or**
☐ Diphenhydramine 25-50 mg PO/IV	☐ Methylprednisolone 125mg IV **
☐ Acetaminophen 650 mg PO	☐ Diphenhydramine 25-50 mg PO/IV
☐Other_____	☐ Acetaminophen 650 mg PO
	☐ Dimenhydrinate (Gravol©) 25-50 mg PO/IV

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

Infusion to be provided at:

SRx Clinics: SRx will arrange appointment ☐ **Hospital Day Medicine**: Prescriber to arrange appointmen

Prescriber Signature: _____ Date: _____

PLEASE FAX COMPLETED FORM TO 587-454-0885

SRx will complete any special authorization forms required on behalf of prescribers. Infusion fee will apply if administered at SRx Clinics. Patient will be provided with a receipt to be used for health spending account (if applicable) or income tax purposes. Patients will be contacted for scheduling at an SRx Clinic within 7 days of the pharmacy having received payment. Prescriber will be provided with post infusion report once infusion has taken place. Prescriber will be notified if SRx is unable to reach patient. For patients booked at Hospital Day Medicine, Drug will be delivered to patients' home; It is the responsibility of patient to take drug to their appointment. Bloodwork may be re-ordered to meet the current standards of the Clinic.