DIRECTCARE Bayshore

Fax or email completed form to:
1-877-261-5196 / directcare@bayshore.ca

Monoferric Patient Enrolment & Medical Order Form

Patient Information

Last Name*	First Name*	Date of Birth* (dd/mmm/yy)	Health Card No.*	Gender*
				☐ M ☐ F

Street Number	Street Name	City/Town	Province	Postal Code
			Select	

Phone (Home)*	Phone (Work)*	Phone (Cell)*	Email*
☐ Y ☐ N Consent to leave message	☐ Y ☐ N Consent to leave message	☐ Y ☐ N Consent to leave message	

Diagnosis	Allergies	Patient on Beta-blocker / ACE inhibitor?
		☐ Y ☐ N Specify

CVAD (please submit protocol directive)				Mobility Device			
☐ Portacath	☐ PICC	☐ N/A		☐ Wheelchair	☐ Walker	☐ None	

Physician Information

Physician Last Name*	Physician First Name*	Designation*	License*

Street Number*	Street Name*	City/Town*	Province*	Postal Code*
			Select	

Physician Office*	Physician Fax*	Physician Email*	Preferred method of communication*
			☐ Phone ☐ Email

Nurse Last Name	Nurse First Name	Nurse Phone	

Medical Order*

Monoferric (Iron Isomaltoside) 100mg/mL (1mL, 5mL, 10mL vials) IV Infusion	Provincial Approval Code*	Body Weight* Kg

Cumulative Iron Need Dosing

Hb (g/dL)	Body Weight		
	<50kg	**50kg to <70kg**	**≥70kg**
≥10	☐ 500mg IV	☐ 1000mg IV	☐ 1500mg IV (1000 mg followed by 500mg one week later)
<10	☐ 500mg IV	☐ 1500mg IV (1000 mg followed by 500mg one week later)	☐ 2000mg IV (1000 mg followed by 1000mg one week later)

Fixed Dose

Body Weight	
≥50kg	**<50kg**
☐ 1000mg IV as a single dose	☐ 20mg/kg IV as a single dose Dose = mg

Other instructions:

PRE-Medications

PRN/PRE Medications

- ☐ Acetaminophen 325-650 mg PO PRN q 4-6 hours for pain, fever or chills
- ☐ Diphenhydramine 25-50 mg PO/IV PRN q 4-6 hours for itching, uticaria, puritis, hives
- ☐ Dimenhydrinate 25-50 mg PO/IV PRN q 4-6 hours for nausea and vomiting
- ☐ Hydrocortisone 100 mg IV PRN x 1 for anaphylactic reaction
- ☐ Epinephrine (1:1000) 0.01 mL/kg (max 0.5 mL) SC/IM PRN q 10-15 minutes x 2 for severe anaphylactic reaction
- ☐ Oxygen via mask/nasal prongs 2-5 L/min PRN for SOB or decreasing 02 sat (below 90% if lower than baseline)
- ☐ Salbutamol 2 puffs q 4-6 hours via aerochamber PRN for dyspnea or wheezing
- ☐ Salbutamol 2.5 mg nebule for inhalation by nebulizer PRN for dyspnea or wheezing x 1 dose
- ☐ Other:

Special Instructions

☐ If there is a variance in the patient's weight of more than (select one) 0 %

☐ I would like a copy of the post-infusion reports ☐ Physician Fax ☐ the following number:

Please contact me

Authorization*

☐ I have reviewed the warnings and precautions for this medication including the risk of infusion associated reactions and the risks of paravenous leakage which can cause irritation of the skin and potential for long-lasting brown discoloration at the injection site with the patient above and/or their substitute decision maker.

Physician Signature* | Date* (dd/mmm/yy)

Patient Consent*

The Bayshore Direct Care™ Program (the "Program") is provided by Bayshore Specialty Rx Ltd. ("Bayshore"). The Program offers certain patient support services which may include, as applicable, nursing services, injection and infusion of medication services, insurance reimbursement assistance and pharmacy services ("Services"). Bayshore reserves the right to modify or terminate the Program at any time without prior notice.

Bayshore is committed to protecting patient confidentiality and patient health information, including without limitation personal information (name, address, contact details, date of birth, financial information) and health information (medical history and conditions, health insurance) (collectively, "Personal Health Information") in accordance with all applicable laws.

My healthcare provider has prescribed certain medication as identified above ("Product/s") for my use and has referred me to the Program. I have discussed the benefits and risks of use of the Product/s with my healthcare provider, I am not relying on the Program for the provision of any medical advice or diagnoses, and I have decided to start treatment on the Product/s. I would like to enrol in the Program to receive Services in relation to Product/s. By signing below, I acknowledge, understand and agree as follows:

☐ The Program shall collect, use, disclose and/or store (collectively, "Use") my Personal Health Information for the purpose of providing the Services, monitoring the Program, reporting adverse events or as may be required by applicable law. My Personal Health Information may be collected from and/or disclosed to my physicians, nurses, pharmacists, insurance providers and others as may be required to provide the Services;

☐ The Program may contact me by telephone or electronic mail using the contact information I have provided above, and I shall be responsible for any resulting telecommunication charges;

☐ My physician may provide this completed, signed Bayshore Direct Care Patient Enrolment & Medical Order form to the Program;

☐ My insurance provider may disclose to the Program my insurance coverage information, and I consent to the Use by the Program of such information for the purpose of verifying coverage and otherwise arranging for reimbursement for the Product/s.

☐ The Program shall be my designated agent for purposes of assisting and selecting the pharmacy that will supply the Product and for purposes of forwarding the prescription, by fax or other mode of delivery, to the pharmacy chosen. This prescription represents the original of the prescription drug order and the receiving pharmacy is the only intended recipient and there are no others. The original prescription has been invalidated and securely filed, and it will not be transmitted by the Program at another time.

☐ My participation in this Program is voluntary, and I may withdraw this consent at any time by calling the Program at 1-877-261-4940 or by mail to Bayshore HealthCare Ltd., Direct Care Program at 2101 Hadwen Road, Mississauga, ON L5K 2L3. I further understand that withdrawal of my consent will end the Use of my Personal Health Information by the Program and will result in termination of my participation in the Program and use of the Services. I may request access to or correction of my Personal Health Information by contacting the Program at 1-877-261-4940 or by mail to Bayshore HealthCare Ltd., Direct Care Program at 2101 Hadwen Road, Mississauga, ON L5K 2L3.

Signature of Patient/Legal Representative* | Printed Name of Patient/Legal Representative* | Date* (dd/mmm/yy)

Verbal Consent Obtained* | Date* (dd/mmm/yy)

☐ Yes