Oshawa Clinic Group | Specialty Pharma Solutions

MONOFERRIC ORDER FORM

FAX TO: 1-855-888-8598

PATIENT INFORMATION

Patient Name: _____ **DOB** (dd/mm/yyyy): _____

Patient Address: _____ **Patient Allergies:** _____

Contact Number(s): _____ **HCN:** _____

Hemoglobin (g/L): _____ **Date:** _____ **Patient Weight:** _____ lbs _____ kg **Date:** _____

PRIMARY MEDICATION ORDER (TOTAL DOSE)

Monoferric® (ferric derisomaltose) 100mg/mL Infusion ***(Choose One)***:

Hemoglobin (g/L)	Bodyweight < 50kg	Bodyweight 50 - 69.9kg	Bodyweight > 70kg
Hgb ≥ 100 g/L	☐ 500mg	☐ 1000mg	☐ 1500mg
Hgb < 100 g/L	☐ 500mg	☐ 1500mg (given in 2 divided doses minimum 7 days apart)	☐ 2000mg (given in 2 divided doses minimum 7 days apart)

If the cumulative iron need exceeds 20 mg iron/kg body weight on day of infusion, the dose will be split into two infusions, given at least one week apart. Administer 20 mg iron/kg body weight in the first infusion (round down to the nearest 500mg).

FREQUENCY

☐ One time infusion (no further infusions will be scheduled unless patient's dose must be split into 2 infusions).

☐ Administer TOTAL DOSE # _____ times, at a frequency of: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly

Note: Clinic nurses will schedule additional appointments until the patient has been given the ordered dose, x number of times at the indicated frequency. Prescribing physician responsible for ordering and monitoring patient blood work and notifying Oshawa Infusion Centre when patient no longer requires treatment.

☐ LU 610 ☐ Private Insurance

PRN MEDS

☐ 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, urticaria, pruritus, 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 0_2 sat (below 90% if lower than baseline)

☐ Salbutamol 2 puffs q 4-6 hours via aerochamber PRN for dyspnea or wheezing

☐ Other: _____ Dose: _____ Route: _____ Sig: _____

PRESCRIBER INFORMATION

Physician Name: _____ **Phone Number:** _____

Physician License #: _____ **Fax Number:** _____

Prescribing Physician Signature: _____ **Date:** _____

Please note, there is a $100 sitting fee for each infusion.

RX WILL BE FILLED BY SPECIALTY PHARMA SOLUTIONS

Order valid for 1 year from date of signature.