

IRON ORDER FORM | MONOFERRIC & VENOFR

Please fax the completed form to 780-306-7308

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
WEIGHT (KG)		FERRITIN	ng/mL
Is patient pregnant, breastfeeding, or under the age of 18?	<input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes → Indicate if any reaction:		

PRESCRIPTION													
<input type="checkbox"/> MONOFERRIC	<input type="checkbox"/> VENOFR												
<p>Simplified Monoferric Weight-Based Table</p> <table border="1"> <thead> <tr> <th>Hb (g/L)</th> <th><50kg</th> <th>50-70kg</th> <th>≥70kg</th> </tr> </thead> <tbody> <tr> <td>≥100</td> <td>500mg</td> <td>1000mg</td> <td>1500mg</td> </tr> <tr> <td><100</td> <td>500mg</td> <td>1500mg</td> <td>2000mg</td> </tr> </tbody> </table> <p>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.</p>	Hb (g/L)	<50kg	50-70kg	≥70kg	≥100	500mg	1000mg	1500mg	<100	500mg	1500mg	2000mg	<p>Simplified Venofer Dosing Table</p> <p>Max Dose for Treatment Regime = 1000mg</p> <p>Max Daily Dose = 300mg</p>
Hb (g/L)	<50kg	50-70kg	≥70kg										
≥100	500mg	1000mg	1500mg										
<100	500mg	1500mg	2000mg										
<p>DOSE</p> <p><input type="checkbox"/> 500mg <input type="checkbox"/> 1000mg <input type="checkbox"/> 1500mg <input type="checkbox"/> 2000mg (induction)</p> <p>Total Number of Doses : _____</p> <p>Interval : <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> Other: _____</p>	<p>DOSING REGIMEN</p> <p><input type="checkbox"/> 200mg IV every ____ week(s) for ____ doses</p> <p><input type="checkbox"/> 300mg IV every ____ week(s) for ____ doses</p> <p><input type="checkbox"/> Other: ____ mg IV every ____ week(s) for ____ doses</p>												

OTHER MEDICATIONS	
<p>If the patient has a HISTORY of reaction to any Iron products, give the following medication IMMEDIATELY prior to the infusion:</p> <p><input type="checkbox"/> Methylprednisolone 125mg IV x1</p> <p><input type="checkbox"/> Diphenhydramine 25-50 mg PO/IV</p> <p><input type="checkbox"/> Acetaminophen 650 mg PO</p> <p><input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> Our clinic follows a standardized protocol to manage reactions during our post-infusion. Please tick this box to indicate that you agree with the following protocol. If your patient has adverse reaction DURING/POST infusion, give:</p> <p><input type="checkbox"/> Hydrocortisone 100mg IV</p> <p><input type="checkbox"/> Methylprednisolone 125mg IV</p> <p><input type="checkbox"/> Diphenhydramine 25-50mg PO/IV</p> <p><input type="checkbox"/> Acetaminophen 650mg PO</p> <p><input type="checkbox"/> Dimenhydrinate Gravol ® 25-50mg PO/IV</p>

PRESCRIBER DETAILS			
<p>Patients will be scheduled at Bliss MediSpa & Integrated Wellness within 7 days of payment for their IV infusion. Prescribers will be notified if the patient cannot be reached. Post-infusion reports are provided. Bloodwork may be updated to meet clinic standards.</p>			
ADDRESS		PHONE	FAX
PRESCRIBER NAME		LICENSE NUMBER	
PRESCRIBER SIGNATURE		DATE (DD/MM/YYYY)	