

## Patient Information

Patient Name:	Diagnosis:
DOB (DD/MM/YYYY):	Allergies:
Phone:	Patient Weight (kg):
Email:	Hgb Levels: Ferritin Levels:
Is the patient: • Under 18 • Pregnant or breast feeding • History of reactions to iron • Has multiple drug sensitivities • Mast-cell disorders or moderate to severe asthma  Yes <input type="checkbox"/> No <input type="checkbox"/>  If yes, please refer to the hospital for treatment. Monoferric is contraindicated for those with hemochromatosis and liver disease.	Does the Patient have a history of medication reactions? Yes <input type="checkbox"/> No <input type="checkbox"/>  Please consider the medications listed below in the related orders section.

## Monoferric Prescription

Select the desired dose based on hemoglobin level & patient weight

Hb (g/L)	<50kg	50-70kg	≥70kg
≥100	<input type="checkbox"/> 500mg	<input type="checkbox"/> 1000mg	<input type="checkbox"/> 1500mg
<100	<input type="checkbox"/> 500mg	<input type="checkbox"/> 1000mg + 500mg	<input type="checkbox"/> 1000mg + 1000mg

**A total Monoferric dose more than 20mg/kg or 1500mg must be divided into 2 doses, a minimum of seven days apart.**

Infusion time: All doses are provided in 250mL NS over 45 minutes.

☐ **Ontario – LU Code: 610**

For the treatment of patients with Iron Deficiency Anemia (IDA) who meet ALL the following criteria:

- Patient has documented diagnosis of IDA confirmed by laboratory testing results (e.g., hemoglobin, ferritin); AND
- Patient's IDA has experienced a failure to respond, documented intolerance, or contraindication to an adequate trial (i.e., at least 4 weeks) of at least one oral iron therapy; AND
- Patient does not have hemochromatosis or other iron storage disorders.

## Infusion Related Reaction - PRN Orders

For patients with **prior reactions**, the following **pre-medications are optional**

- ☐ Cetirizine 10-20mg PO
- ☐ Dimenhydrinate 25-50mg PO
- ☐ Tylenol 650mg PO

In the event of an **adverse reaction**, the following **medications** may be administered for **symptom management**:

- ☐ Cetirizine 10-20mg PO
- ☐ Dimenhydrinate 25-50mg PO/IV
- ☐ Tylenol 650mg PO
- ☐ Epinephrine 1:1000 .5mg IM

## Prescribers Information

Prescriber's Name:	Phone Number:
Fax Number:	Billing Number:
Prescriber's Signature:	
Date (DD/MM/YYYY):	