

# IRON PRESCRIPTION FORM



☐ Mississauga ☐ Windsor ☐ Hamilton ☐ Welland ☐ Orangeville

## Patient Information

|                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Patient Name:                                                                                                                                                                                                                                                                                                                                                                                        | Diagnosis:                                                                                                                                                                                                                                                                                                                                                                   |
| DOB (DD/MM/YYYY):                                                                                                                                                                                                                                                                                                                                                                                    | Allergies:                                                                                                                                                                                                                                                                                                                                                                   |
| Phone:                                                                                                                                                                                                                                                                                                                                                                                               | Patient Weight(kg):      Date of Weight(DD/MM/YYYY):                                                                                                                                                                                                                                                                                                                         |
| Email:                                                                                                                                                                                                                                                                                                                                                                                               | Hgb Levels:      Ferritin Levels:                                                                                                                                                                                                                                                                                                                                            |
| <p>Is the patient:</p> <ul style="list-style-type: none"> <li>Under 18</li> <li>Pregnant or breast feeding</li> <li>History of reactions to iron</li> <li>Has multiple drug sensitivities</li> <li>Mast-cell disorders or moderate to severe asthma</li> </ul> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes to the above, please refer the patient to the hospital.</p> | <p>Does the Patient have a history of medication reactions?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please consider infusion related medications below.</p> <p>Does the patient have history of previous Iron Infusions?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date of last infusion (DD/MM/YYYY): _____</p> |

## Iron Prescription

☐ **Monoferri** Maximum dose for treatment: 20mg/kg.

Maximum single dose 1500mg. >1500mg will be divided into 2 doses, a minimum of 7 days apart.

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

LU code

☐ 610

Infusion time: All doses are administered in 250ml NS over 45 minutes.

☐ **Ferinject** Maximum dose for treatment: 15mg/kg.

Maximum single dose 1000mg. >1000mg will be divided into 2 doses, a minimum of 7 days apart.

| Hb (g/L)   | 35-70kg                                 | ≥70kg                                    |
|------------|-----------------------------------------|------------------------------------------|
| <100       | <input type="checkbox"/> 1000mg + 500mg | <input type="checkbox"/> 1000mg + 1000mg |
| >100 - 140 | <input type="checkbox"/> 1000mg         | <input type="checkbox"/> 1000mg + 500mg  |
| ≥140       | <input type="checkbox"/> 500mg          | <input type="checkbox"/> 500mg           |

LU code

☐ 735

☐ 736

Infusion time: All doses are administered in 100ml NS over 30 minutes.

## Infusion Related Medication Options

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):      |                 |

Please fax completed form to 1-888-289-2507