


IRON ORDER FORM | MONOFERRIC & VENOFRER

Please fax the completed form to 1-866-640-1749

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	FERRITIN	ng/mL
WEIGHT (KG)		ALLERGIES			
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"/> ONTARIO - LU Code: 610	<input type="checkbox"/> VENOFRER												
<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										
DOSE	DOSING REGIMEN												
<input type="checkbox"/> 500mg <input type="checkbox"/> 1000mg <input type="checkbox"/> 1500mg <input type="checkbox"/> 2000mg (induction) Total Number of Doses: _____ Interval: <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> Other: _____	<input type="checkbox"/> 200mg IV every ____ week(s) for ____ doses <input type="checkbox"/> 300mg IV every ____ week(s) for ____ doses <input type="checkbox"/> Other: ____ mg IV every ____ week(s) for ____ doses												

OTHER MEDICATIONS		
If the patient has a HISTORY of reaction to any Iron products, give the following medication IMMEDIATELY prior to the infusion: <input type="checkbox"/> Methylprednisolone 125mg IV x1 <input type="checkbox"/> Diphenhydramine 25-50 mg PO/IV <input type="checkbox"/> Acetaminophen 650 mg PO <input type="checkbox"/> Other:	<input type="checkbox"/> Our clinics follow a standardized protocol to manage reactions during our post-infusion. Please tick this box to indicate that you agree with the following protocol. If the patient has adverse reaction DURING/POST infusion, give: <input type="checkbox"/> Hydrocortisone 100mg IV <input type="checkbox"/> Methylprednisolone 125mg IV <input type="checkbox"/> Diphenhydramine 25-50mg PO/IV <input type="checkbox"/> Acetaminophen 650mg PO <input type="checkbox"/> Dimenhydrinate Gravol® 25-50mg PO/IV	Current infusion reaction protocol includes the use of these medications according to nurse's assessment. Scan the QR Code to download the full Reaction Guidance Document. 

PRESCRIBER DETAILS			
SRx will handle special authorization forms and apply an infusion fee at SRx Clinics. Patients receive a receipt for tax or health account purposes. Patients will be scheduled at an SRx Clinic within 7 days of payment. Prescribers will be notified if the patient cannot be reached. Post-infusion reports are provided. For Hospital Day Medicine appointments, patients receive home-delivered drugs to bring to their appointment. Bloodwork may be updated to meet clinic standards.			
ADDRESS		PHONE	FAX
PRESCRIBER NAME		LICENSE NUMBER	
PRESCRIBER SIGNATURE		DATE (DD/MM/YYYY)	

