VENOFER (IRON SUCROSE) ORDER FORM

Patient Information

Name:	DOB (dd/mm/yyyy):	Weight:	PHN:
Address:	Allergies:	Phone number:	Emergency contact number

Prescriber Information

Name:	Phone number:	Fax number:

Clinic Information:

Diagnosis: _____

Patient Hemoglobin: _____ Ferritin: _____

Has patient tried oral iron supplementation? ☐ Yes ☐ No

Comments: _____

Has patient received IV Iron previously and if so was there a reaction?

Details: _____

VENOFER Dosing – Simplified Table-please select one

☐ Iron Sucrose (Venofer)	200 mg in 50 ml 0.9% normal saline	@ 200 ml /hour (ie. 15 min)
☐ Iron Sucrose (Venofer)	300 mg in 250 ml 0.9% normal saline	@ 165 ml /hour (ie. 90 min)

IV Iron Frequency and Duration for Recurrent Doses

☐ NO Repeat OR ☐ Repeat the above iron dose every _____ week(s) X_____ (Example: 300mg every week x 4 doses)

Infusion to be provided at:

☐ **SRX Clinics:** SRx will arrange infusion appointment.

☐ **Hospital Day Medicine:** Prescriber to arrange infusion appointment, prescriber to sign and attach AHS waiver for unfunded drug form.

Please check off the below:

If the patient has a HISTORY of reaction to any Iron products: **Give:** ☐ Methylprednisolone 125mg IV x1 ☐ Diphenhydramine 25-50 mg PO/IV ☐ Acetaminophen 650 mg PO ☐ Other: _____	**If the patient has adverse reaction DURING/POST infusion:** **Give:** ☐ Hydrocortisone 100mg IV ☐ Diphenhydramine 25-50 mg PO/IV ☐ Acetaminophen 650 mg PO ☐ Dimenhydrinate (Gravol©) 25-50 mg PO/IV

Prescriber Signature: _____ **Date:** _____

SRx will complete any special authorization forms required on behalf of prescribers. Infusion fee of $80 will apply if administered at SRx Clinics. Patient will be provided with a receipt to be used in health spending account (if applicable) or for income tax purposes. Patients will be scheduled at an SRx Clinic within 7 days of the pharmacy having received payment. Prescriber will be provided with post infusion report once infusion has taken place. Prescriber will be notified if SRx is unable to reach patient, or patient elects to not proceed with infusion. For patients booked at Hospital Day Medicine, Drug will be delivered to patients' home; It is the responsibility of patient to take drug to their appointment.

PLEASE FAX COMPLETED FORM TO 1-866-640-1749

SRx CLINICS