Local Infusion

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# MONOFERRIC (FERRIC DERISOMALTOSE) ORDER FORM

## PATIENT INFORMATION

Patient Name: ______________________________ DOB: ______________

Mobile Number: ______________________ Patient Weight: ______________________

Allergies: ______________________________________________

## PRIMARY DIAGNOSIS (Provider must specify)

- ❑ Iron Deficiency Anemia, ICD 10: D50.______________________________
- ❑ CKD: Stage ______, ICD 10: N18.______________________________
- ❑ Other: ______________________________________________

## SECONDARY DIAGNOSIS (Provider must specify)

- ❑ Anemia in CKD, ICD 10: D63.1
- ❑ Anemia in Chronic Disease, ICD 10: D63.8

## PROVIDER INFORMATION

Provider Name (print name): ______________________________ Provider NPI: ______________

Signature: ______________________________ Date: ______________

Contact Name: ______________________ Phone: ______________ Fax: ______________

Email Address: ______________________________________________

**Prerequisites to treatment –** ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

## PRE-MEDICATION (Not typically indicated)

- ❑ Acetaminophen (Tylenol) 500 mg PO
- ❑ Famotidine 20 mg IV
- ❑ Methylprednisolone (Solu-Medrol) 125 mg IVP
- ❑ Benadryl 25mg PO
- ❑ Cetirizine (Zyrtec) 10 mg PO
- ❑ Other: ______________________ Dose: ______________ Route: ______________

## MEDICATION

| MEDICATION | DOSE | ROUTE | FREQUENCY |
|---|---|---|---|
| Monoferric | ❑ 1000 mg (Wt at least 50 kg) ❑ 20 mg/kg (Wt less than 50 kg | ❑ IV | ❑ x1 dose |

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): ______________

## LABS / SPECIAL INSTRUCTIONS

**FAX NUMBERS:** ❑ NH: 603.217.5371 ❑ ME: 207.407.7272

Order valid for 1 year from date of signature unless otherwise specified here: ____________