Cumberland Vital Care

Fax Referral To:

(931) 456-4857

Direct Phone: (931) 456-0680

MONOFERRIC ORDER FORM

Date:___________________________________

Patient Name: ___________________________________

Date of Birth: ___________________________________

Allergies: ___________________________________

Weight: __________ lbs OR ___________ kg

ICD-10 Code:

- ☐ D50.0 Iron deficiency anemia secondary to blood loss (chronic)
- ☐ D50.8 Other iron deficiency anemia
- ☐ D50.9 Iron deficiency anemia, unspecified
- ☐ D63.1 Anemia in chronic kidney disease (Code CKD Stage First)
- ☐ D63.8 Anemia in other chronic disease (Code underlying disease first)
- ☐ Other:____

Therapy Status

Please check any of the following that apply:

- ☐ *Patient has previously failed oral iron therapy.*
- ☐ *Patient has previously been treated with Monoferric or other IV iron.*
- ☐ *Patient has previously experienced an adverse reaction from an iron therapy.*
- ☐ *Patient has chronic renal disease.*

Provider Information

Ordering Provider: _________________________

Provider NPI: _____________________________

Provider Phone: ___________________________

Provider Fax: _____________________________

Provider Address: __________________________

MEDICATION ORDER

Monoferric	☐ Patients weighing 50kg or more: Administer Monoferric 1,000mg IV x one dose per protocol. ☐ Patients weighting less than 50kg: Administer Monoferric 20mg/kg IV x one dose per protocol.	✓ *Patient will be observed for signs and symp-toms of hyper-sensitivity during infusion and for at least 30 minutes post infusion.*	**Please include the following lab results required for infusion:** ✓ *Hemoglobin and Hematocrit within past 60 days* ✓ *Iron Studies within past 60 days*

PRE MEDICATIONS

☐ Oral

- ☐ Acetaminophen: ___325mg ___500mg __650mg
- Loratadine: 10 mg
- ☐ Cetirizine: 10mg
- ☐ Diphenhydramine: ___25mg ___50mg
- ☐ Famotidine: ___20mg ___40mg
- ☐ Ibuprofen: ___200mg ___400mg ___600mg
- ☐ Ondansetron: ___4mg ___8mg
- ☐ Other__________________________

☐ IV

- ☐ Dexamethasone: ___4mg ___8mg
- ☐ Diphenhydramine: ___25mg __50mg
- ☐ Famotidine: ___20mg ___40mg
- ☐ Methylprednisolone 125mg
- Hydrocortisone 100mg
- ☐ Ondansetron: ___4mg ___8mg
- ☐ Other________________________

LAB ORDERS (Please indicate any labs to be drawn and frequency)

Surveillance lab ordering, and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Ofice Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Dispense as Written:

________________________________ __________

Prescriber Name Date

Substitution Allowed:

________________________________ __________

Prescriber Name Date