MonoFerric

Orders

FERRIC DERISOMALTOSE

Email: intake@infuseoneohio.com
Fax: (614) 929-7199
Phone: (614) 929-3349

Locations: ☐ Dublin, OH ☐ Lancaster, OH

INFUSE ONE OHIO

PATIENT INFORMATION

Patient Name _____ **Date of Birth** _____ **Gender** ☐ M ☐ F

Patient Address / City / State / ZIP _____ **Phone** _____

DIAGNOSIS

PLEASE PROVIDE ICD-10 CODE

☐ Iron Deficiency Anemia _____ ☐ Other _____

PRE-MEDICATIONS

OPTIONAL - CHECK ALL THAT APPLY

☐ Acetaminophen 1000 mg PO

☐ Diphenhydramine 25 mg PO

☐ Cetirizine 10 mg PO

☐ Other _____

☐ Solu-Medrol 125 mg IVP

☐ Solu-Cortef 100 mg IVP

☐ Diphenhydramine 25 mg IVP

☐ Other _____

MONOFERRIC ORDERS

DOSAGE & FREQUENCY - CHOOSE ONE

☐ 1,000 mg IV over at least 20 minutes (patients 50 kg or more)

☐ 20 mg/kg actual body weight IV over at least 20 minutes (patients <50 kg)

☐ Other _____

PATIENT WEIGHT

Pounds _____ **Kilograms** _____

Please fax the patient's ferritin or TSAT results with this completed form.

NOTES

ORDERING PROVIDER

Provider NPI _____ **Phone** _____ **Fax** _____

Provider Name _____

Provider Address _____

Prescriber Signature _____ **Date** _____