immersiv HEALTH

MONOFERRIC® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ D50.0 Iron Deficiency Anemia secondary to blood loss

☐ D50.9 Iron Deficiency Anemia

☐ O99.019 Anemia complicating pregnancy

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information

☐ List of Medications

☐ Tried & Failed Therapies

☐ Most Recent History & Physical

☐ Recent hemoglobin, hematocrit and iron studies

MEDICATION ORDER

***For patients Weighing Less Than 50kg**

☐ Monoferric® (ferric derisomaltose) 20mg/kg ACTUAL BODY WEIGHT IV in 500ml NS over 30 minutes

***For patients Weighing greater Than 50kg**

☐ Monoferric® (ferric derisomaltose) 1000mg IV in 500ml NS over 30 minutes

Patient to be observed for 30 minutes following infusion.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ | _____ **DATE:** _____
(NO STAMPS)

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN