

**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. Administer per protocol.  
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