Iron (Monoferric)

Provider Order Form *rev. 01/24/2025*

IVCARE INFUSION
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PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per IVCare Infusion's Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVCare Infusion's Adverse Reaction Management Protocol available upon request

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

SPECIAL INSTRUCTIONS

_____

*Closely observe patients for signs and symptoms of hypersensitivity including monitoring of blood pressure and pulse during and after Monoferric administration for at least 30 minutes and until clinically stable following completion of each infusion.

THERAPY ADMINISTRATION

☑ Monoferric Monoferric® (ferric derisomaltose) injection

☐ **Patient weighing less than 50kg (110 lbs.)**

Dose: Monoferric 20mg/kg IV x 1 dose

☐ **Patient weighing 50kg (110 lbs.) or greater**

Dose: Monoferric 1000mg IV x 1 dose

☑ **Anaphylactic Reaction Orders:**

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen® 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x 1
  - 15-30kg (33-66lbs): EpiPen® 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x 1
- Solu-Medrol 125mg IV as needed (adult), refer to provider orders or policy for pediatric dosing
- NS 250-500 mL IV bolus as needed (adult), refer to provider orders or policy for pediatric bolus

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

☑ Patient required to stay for 30-min observation period

Provider Name (Print) **Provider Signature** **Date**