IV Iron Order Form

Fax completed form to **f:** 1 (855) 554-1170
t: 1 (855) 737-2876 | **e:** percuroinfusion@sentrex.com

PerCuro by sentrex

***Note:** Provide the patient with a copy of the Rx if they are using their own pharmacy.

PATIENT INFORMATION

Name: (First, Last) _____ Date of Birth: (dd-mmm-yyyy) _____

Gender: ○ Female ○ Male ○ Other Language: ○ EN ○ FR ○ Other: _____

Patient Email: _____ Health Card Number: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Primary Phone: _____ OK to leave message? ○ Y ○ N

Best time to contact: ○ Morning ○ Afternoon ○ Evening Patient Allergies: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

PRESCRIPTION INFORMATION

Baseline Labs and Prior Therapy

Date of Blood Draw: (dd-mmm-yyyy) _____ Hemoglobin: _____g/L Ferritin: _____ng/mL

Indication: _____

Relevant Medical History/Notes: _____

Medication

○ Ferric carboxymaltose (Ferinject)	_____mg IV over at least 15 minutes.	The final concentration should not be less than 2 mg/mL. Single doses should not exceed 15 mg/kg or 1000 mg in adults, or 15 mg/kg or 750 mg in pediatrics. If more than one infusion is required to administer the prescribed dose, doses should be administered at least 7 days apart.
○ Iron Sucrose (Venofer)	○ 100 mg IV in 100 mL normal saline over at least 15 minutes ○ 200 mg IV in 100 mL normal saline over at least 15 minutes ○ 300 mg IV in 250 mL normal saline over at least 1.5 hours	○ 400 mg IV in 250 mL normal saline over at least 2.5 hours ○ 500 mg IV in 250 mL normal saline over at least 3.5 hours
○ Ferric Derisomaltose (Monoferric)	_____mg IV. Doses ≤ 1000 mg IV administer over at least 20 minutes; Doses > 1000 mg IV administer over at least 30 minutes.	If cumulative iron need exceeds 20 mg/kg body weight, the dose must be split into two administrations with an interval of at least one week. Single doses above 1500mg are not recommended. If more than one infusion is required to administer the prescribed dose, divide the dose as per product monograph with an interval of one week between infusions: Dilute doses up to 200 mg in 50 mL of normal saline. Dilute doses greater than 200 mg in 100 mL of Normal Saline. The final concentrations must not be less than 1 mg/mL.

Patient Weight

Patient weight: _____kg Date of weight: (dd-mmm-yyyy) _____

Pregnancy

○ N/A ○ Prescriber confirms patient is at least 16 weeks pregnant and understands PerCuro does not have fetal monitoring available

Treatment Interval

○ Once ○ Weekly (every 7 days) ○ Biweekly (every 14 days) ○ Monthly (every ___ months) **Number of Treatments:** _____

○ Repeat Blood Draw to be completed & reviewed by prescriber at _____ interval. ○ Results to be forwarded to PerCuroInfusion@sentrex.com

Pre-Infusion and PRN Treatments

Pre-infusion

○ N/A
○ x1 Hydrocortisone: 100 mg IV 30 mins pre-infusion
○ x1 Acetaminophen: 325-650 mg PO 30 mins pre-infusion
○ x1 Methylprednisolone: _____ mg IV 30 mins pre-infusion
○ Other: _____

Comments: _____

Prescriber Information

Prescriber Name: (printed) _____ License #: _____

Signature: _____ Date: (dd-mmm-yyyy) _____

Clinic Address: _____ City: _____ Province: _____ Postal Code: _____

Clinic Phone: _____ Clinic Fax: _____

PATIENT CONSENT

By signing below, I confirm that the information I have provided in this application is complete and accurate. I authorize Sentrex Health Solutions and its agents to obtain medical and personal information from my prescribing physician, pharmacist, nurse, insurer, government agency, employer, or other sources as deemed necessary to ensure the accuracy and completeness of this application.

○ Verbal Consent Obtained

Signature of Patient: (or Patient's Legal Representative) Date: (dd-mmm-yyyy)

Printed name of Patient: (or Patient's Legal Representative) Relationship to Patient:

Name of Person Providing Verbal Consent: _____ Date: (dd-mmm-yyyy) _____

*Please note, an infusion fee will be applied to each infusion

Upon completion, fax to: 1 (855) 554-1170