Fax: 614-929-7199 | Phone: 614-929-3349| Email: info@infuseoneohio.com

(ferric derisomaltose)

MonoFerric infusion orders

INFUSE ONE

Patient Name _____ DOB _____

Phone Number _____ M ____ F _____

DIAGNOSIS *Please provide ICD-10 code*

☐ _____Iron Deficiency Anemia ☐ _____ Other

PRE-MEDICATIONS (optional)

- ☐ Acetaminophen 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____ (other)
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ (other)

MonoFerric (ferric derisomaltose) ORDERS

DOSAGE & FREQUENCY

Dose (choose one)

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

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

☐ Other: _____

Patient Weight

_____ lbs

_____ kg

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

NOTES:

ORDERING PROVIDER

Signature _____ Phone_____Fax_____

Provider _____ Date _____