CareMed
WELLNESS CLINIC
LONGEVITY . CARE . WELL BEING

IRON ORDER FORM | MONOFERRIC, VENOFER & FERINJECT

Please fax the completed form to 1-877-384-2278

PATIENT DETAILS			
NAME		DATE OF BIRTH (DD/MM/YYYY)	
PHONE		EMAIL	
ADDRESS		HEALTH CARD NUMBER	
EMERGENCY CONTACT NAME		EMERGENCY CONTACT NUMBER	

CLINICAL DETAILS					
DIAGNOSIS		HEMOGLOBIN	g/l	FERRITIN	ng/mL
WEIGHT (KG)		ALLERGIES			
Is patient pregnant, breastfeeding, or under the age of 18?	☐ No ☐ Yes → Please prescribe Venofer instead as Monoferric is not currently approved for use in pregnancy/lactation or patients under age 18 in Canada. Please note that Venofer should not be given to pregnant women in the first trimester.				
Has patient received IV iron previously?	☐ No ☐ Yes → Indicate if any reaction:				

PRESCRIPTION

☐ MONOFERRIC

Simplified Monoferric Weight-Based Table

Hb (g/L)	<50kg	50-70kg	≥70kg
≥100	500mg	1000mg	1500mg
<100	500mg	1500mg	2000mg

Doses that exceed the weight-based chart above, 20mg iron/kg body weight, or 1500mg, must be split into multiple doses separated by at least 7 days (Induction Dose). If the dose is not clearly specified, the product monograph administration guidelines will be followed.

DOSE

☐ 500mg ☐ 1000mg ☐ 1500mg ☐ 2000mg (induction)

Total Number of Doses: _____

Interval: ☐ 2 months ☐ 3 months ☐ 6 months ☐ Other: _____

☐ VENOFER

Simplified Venofer Dosing Table

Max Dose for Treatment Regime = 1000mg

Max Daily Dose = 300mg

DOSING REGIMEN

☐ 200mg IV every _____ week(s) for _____ doses

☐ 300mg IV every _____ week(s) for _____ doses

☐ Other: _____ mg IV every _____ week(s) for ____ doses

☐ FERINJECT

A single administration should (max. 1000 mg). Administer at least 7 days. If additional dose needed.

Weight	Hemoglobin		
	< 10 g/dL	10 to < 14 g/dL	≥14 g/dL
< 35 kg	500 mg IV	500 mg IV	500 mg IV
35 kg - < 70 kg	1500 mg IV	1000 mg IV	500 mg IV
≥70 kg	2000 mg IV	1500 mg IV	500 mg IV

OTHER MEDICATIONS

If the patient has a HISTORY of reaction to any Iron products, give the following medication IMMEDIATELY prior to the infusion:

☐ Methylprednisolone 125mg IV x1
☐ Diphenhydramine 25-50 mg PO/IV
☐ Acetaminophen 650 mg PO
☐ Other:

☐ Our clinics follow a standardized protocol to manage reactions during our post-infusion. Please tick this box to indicate that you agree with the following protocol. If the patient has adverse reaction DURING/POST infusion, give:

☐ Hydrocortisone 100mg IV
☐ Methylprednisolone 125mg IV
☐ Diphenhydramine 25-50mg PO/IV
☐ Acetaminophen 650mg PO
☐ Dimenhydrinate Gravol© 25-50mg PO/IV

☐ 500 mg
☐ 1000 mg

Total number of doses

ADDRESS		PHONE		FAX	
PRESCRIBER NAME		LICENSE NUMBER			
PRESCRIBER SIGNATURE		DATE (DD/MM/YYYY)			

All medications, IV solutions, and related supplies used in IV therapy are dispensed and provided by CareMed pharmacy in full compliance with applicable regulatory and safety standards.

To ensure product safety and integrity, CareMed Wellness Clinic does not accept or administer any medications or IV products sourced or filled by a pharmacy other than CareMed Pharmacy. All medications used in treatment must be dispensed directly through CareMed Pharmacy.