CURBSIDE INFUSION SERVICES

Monoferric (ferric derisomaltose)

Order Form

PATIENT INFORMATION

Date: Patient Name: DOB:

Allergies: Weight (kg): Height (cm):

ICD-10 Code(s) & Description *(required)*: **Referral Status:** ○ New Referral ○ Updated Order ○ Order Renewal

☐ *(required)* The patient's demographics, insurance, lab results, meds and recent visit notes were sent to IA.

The patient has an existing prior authorization: ◉ Yes *(please fax IA a copy)* ◉ No *(IA will process for you)*

PRESCRIBING OFFICE

Contact Name: Contact Phone Number:

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

CLINICAL HISTORY

Is this referral **URGENT** (to be administered within 5-7 days)? ○ Yes ○ No

If yes, please list rationale: _____

Does patient have chronic kidney disease? ○ Yes ○ No

If yes, what stage and ICD10 code? _____

Hemoglobin: _____ Date collected: _____ Ferritin: _____ Date collected: _____

Is patient on hemodialysis? ○ Yes ○ No Is patient currently on an erythropoietin product? ○ Yes ○ No

Is patient unable to tolerate, or had inadequate response to oral iron supplements? ○ Yes ○ No

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Monoferric (ferric derisomaltose) IV

Dose: ○ Infusion Associates provider to dose Monoferric, **OR**

- ○ 1000 mg (for patients weighing >50 kg) x 1 dose
- ○ 20 mg/kg (for patients weighing <50 kg) x 1 dose
- ○ 500 mg x 3 doses over 7 days

Date of last infusion : _____ RX Expiration Date: _____

Additional Notes from Referring Office:

_____ _____ _____

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