



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

**The information contained in this document will become a legal prescription. Follow all state Medical Board guidelines when completing, inclusive of guidelines that pertain to the number of prescriptions allowed on a single prescription form. If more than one page is required, make additional copies. Use state board mandated language for dispensing brand name medications or generic substitution and follow physician signature requirements. Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. By signing this form and using our services, you are authorizing Curbside Infusion to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

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