Iron (Monoferric, Ferinject and Venofer) Order Form

Send completed form to Coverdale Infusion Clinics: Fax:1-888-236-3502 or by email: enrollment@coverdaleclinic.com

An infusion fee will apply and is payable by credit card to the Coverdale Resource Center at the time of booking. Please note that a cancellation fee may also apply.

PATIENT INFORMATION

Patient Name:	DOB (dd/mm/yyyy):	Patient Address:	
Patient Allergies:	Patient Phone Number: ( ) -	Patient Email:	Patient Health Card Number:
Emergency Contact Name:	Emergency Contact Phone Number: ( ) -		

PATIENT CLINICAL DETAILS

Diagnosis:	Hemoglobin: _____ (g/L)	Ferritin: _____ (ng/mL)
Patient Weight (kg):	Date of Weight: (dd/mm/yyyy):	First Iron Infusion? ☐ Yes ☐ No
Relevant Medical History/Notes:		

PRESCRIBER INFORMATION

Prescribing Physician Name:	Prescribing Physician License #:	Address:
Prescriber Phone Number: ( ) -	Prescriber Fax Number: ( ) -	Email:

PRESCRIPTION INFORMATION

MONOFERRIC: Adult or Off label Pediatric *see pediatric section below

☐ **Adult Protocol Infusion Dose** (select one): ☐ **500 mg** ☐ **1000 mg** ☐ **1500 mg** ☐ **Other: 20 mg/kg x _____ kg = _____ mg** of Monoferric
Note: Single doses above 1500 mg are not recommended. If the total dose exceeds 20 mg iron/kg, it must be split into 2 infusions at least 1 week apart. It is recommended, when possible, to give 20 mg/kg in the first infusion

☐ **Adult Protocol IV Bolus Injection** Administer _____ mg (up to 500 mg) of **Monoferric** once per week at a rate of up to **250 mg/minute**.

Off label: ☐ **Pediatric Protocol (SickKids Protocol below): Ordered Dose: _____ mg**
If nausea or reaction occurs, nurse may administer: **DimenHYDRINATE – 1 mg/kg (up to 50 mg) × 1 dose while in clinic**
Infuse slowly over 2 hours, titrating as tolerated. Monitor vitals every 15 minutes. Post-infusion observation: 30 minutes (or per nursing judgment).

Frequency (Select one):
☐ **One-time dose** (If the total dose exceeds 20 mg/kg or 1500 mg, the dose must be split into two infusions at least one week apart)
☐ **Repeat Dosing Schedule** Administer #_____ infusions at a frequency of: ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Other: _____
Note: Prescribing physician is responsible for monitoring bloodwork and notifying Coverdale when no further treatment is required.

PRE-MEDICATIONS

☐ None required ☐ Other:

FERINJECT: Adult or Pediatric

☐ **Intravenous Infusion** (diluted in sterile 0.9% Sodium Chloride as per manufacturer's recommendations)
☐ **Intravenous Injection** (undiluted)
Dose (Select one or write dose below):

Determination of the Total Iron Need – Adults 18+

Hb (g/L)	Bodyweight <35 kg	Bodyweight 35 to <70 kg	Bodyweight ≥70 kg
<100	☐ 500 mg	☐ 1500 mg	☐ 2000 mg
100 to <140	☐ 500 mg	☐ 1000 mg	☐ 1500 mg
≥140	☐ 500 mg	☐ 500 mg	☐ 500 mg

Determination of the Total Iron Need – Pediatric Ages 1 to 17 Years

Hb (g/L)	Bodyweight 10 kg	Bodyweight 20kg	Bodyweight 30kg	Bodyweight 40kg	Bodyweight 50kg	Bodyweight 60kg
70	☐ 300	☐ 600	☐ 900	☐ 1200	☐ 1350	☐ 1500
90	☐ 250	☐ 500	☐ 750	☐ 1100	☐ 1200	☐ 1350
110	☐ 200	☐ 400	☐ 600	☐ 900	☐ 1000	☐ 1100
130	☐ 150	☐ 300	☐ 450	☐ 700	☐ 750	☐ 800
≥150	☐ 150	☐ 300	☐ 450	☐ 500	☐ 500	☐ 500

☐ **Other: _____ mg**
Based on the total iron requirement, administer FERINJECT as follows: Max single dose: 15 mg iron/kg body weight or 1000 mg (adults)/750 mg (pediatric).
Max weekly dose: 1000 mg (adults) and 750 mg (pediatric). **Pregnancy dosing (≥16 weeks): Max dose** – 1000 mg (Hb > 90), 1500 mg (Hb ≤ 90).

References: Ferinject Product Monograph, 27.06.2024; Monoferric Product Monograph 29.01.2025; CHEO Ed Outreach Reference Manual DIN 02477777; Venofer Product Monograph, 14.02.2023.

Version: 05.09.2025

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Frequency:

☐ ☐ **One-time dose** (if dose is >1000mg (adults) or 750mg (pediatric), the dose must be split into two doses at least 7 days apart).

☐ ☐ **Split dosing required** (please specify): Day 0: _____ mg, Day ____: _____mg, Day ____: _____mg

Reassess Hb levels no sooner than 4 weeks after the final dose. If additional iron is needed, recalculate the required dose and submit a new medical order.

PRE-MEDICATIONS

☐ None required ☐ Other:

VENOFER: Adults or Off label Pediatric *see pediatric section below

Length of infusion: Infuse IV over _____ minutes **Dose and route:** _____mg IV

Frequency of dosing: Administer every _____ (days/weeks/months) x _____ doses

PRE-MEDICATIONS

☐ None required ☐ Other:

Pregnancy Considerations:

Is patient pregnant? ☐ No ☐ Yes – If yes, by proceeding, you acknowledge that Monoferric, Venofer and Ferinject should only be used during pregnancy from gestation week 16 onward (specified in the Monoferric and Ferinject Product Monographs), when the benefit outweighs the risk to both mother and fetus, as per the Product Monograph. You have discussed the risks with the patient/guardian and wish to proceed.

Pregnancy dosing (≥16 weeks): Max dose – 1000 mg (Hb > 90), 1500 mg (Hb ≤ 90).

Please specify infusion parameters for pregnant patients:

Start infusion slow for _____ minutes, slowly titrate up to infuse over _____ minutes as tolerated.

Monitor vital signs every _____ minutes. Post-infusion monitoring: _____ minutes.

Pediatric Considerations:

Pediatric Use Acknowledgement (MONOFERRIC and VENOFER): As per the Monoferric/Venofer Product Monograph, this medication has not been studied in pediatric populations and is not authorized by Health Canada for pediatric use. By signing below, you confirm that the risks have been discussed with the patient/guardian and that you wish to proceed with treatment as ordered. **Please indicate any additional protocols:**

I authorize Coverdale Resource Centre to act as my designated agent to forward this prescription to the pharmacy chosen by the patient named above. This prescription is the original order and is intended solely for the patient's selected pharmacy.

Prescriber Signature:	**Date (dd/mm/yyyy):**

References: Ferinject Product Monograph, 27.06.2024; Monoferric Product Monograph 29.01.2025; CHEO Ed Outreach Reference Manual DIN 02477777; Venofer Product Monograph, 14.02.2023.