Monoferric Enrollment Form

Date: ______________________

Patient Name: ______________________

Date of Birth: ______________________

TwelveStone Health Partners
Fax Referral To:
(800) 223-4063
Direct Phone: (615) 278-3350
Toll Free: (844) 893-0012

PREVIOUS ADMINISTRATION

If YES, please provide the following information:

Last Infusion Date: ______________________

Next Infusion Date: ______________________

If NO, please indicate desired location for first dose:

☐ Physician's Office

TwelveStone Infusion Center:

☐Canton ☐Chattanooga ☐Knoxville ☐Mount Juliet ☐Murfreesboro

☐ Other: ______________________

Desired Start Date: ______________________

DIAGNOSIS

Description	*ICD-10 Code*
☐ Iron Deficiency Anemia	☐ D50.9 ☐ Other:_______

OTHER REQUIRED DOCUMENTATION *(Please attach documents as needed)*

☐ This signed order form

☐ History and Physical

☐ Patient Demographics and Insurance Information

☐ Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

CLINICAL INFORMATION *(Please attach all clinical information, lab results and other medical history documents)*

Patient Weight: :________ Kg Height: __________Inches/CM BSA :______________ Allergies: ______________________

Line Access: ☐ PIV ☐ PICC (SL DL TL) ☐ PORT (Huber size________Gauge_____Length) ☐ Sub-Q

MEDICATION	DIRECTIONS	REFILLS	BASELINE LABWORK REQ'D TO INITIATE (Check for TwelveStone to draw)
☐ Monoferric	☐ <u><50kg</u> - Infuse 20mg/kg (_____ mg) IV over a minimum of 20 minutes. Observe for 30 minutes after infusion. ☐ <u>= or > 50kg</u> - Infuse 1000 mg IV over a minimum of 20 minutes. Observe for 30 minutes after infusion.		☐ CBC w/Differential ☐ HGB, HCT, TIBC, Ferritin

LAB ORDERS - To be drawn by TwelveStone

Order	Frequency
CBC w/Differential	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
CBC w/o Differential	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
CMP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
BMP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
CRP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Sed Rate	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Calcium	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Tb QuantiFERON Gold	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Hepatitis Panel	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Other________________________________	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________

PRE-MEDICATIONS - *RECOMMENDED/Check Here if NO Pre-Meds _____

Oral	IV
Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg	Dexamethasone: ☐ 10mg
Cetirizine: ☐ 10mg	Diphenhydramine: ☐ 25mg ☐ 50mg
Diphenhydramine: ☐ 25mg ☐ 50mg	Famotidine: ☐ 20mg ☐ 40mg
Famotidine: ☐ 20mg ☐ 40mg	Methylprednisolone: ☐ _____mg IV over ______ mins
Ibuprofen: ☐ 200mg	Ondansetron: ☐ 4mg ☐ 8mg
Loratadine: ☐ 10mg	
Ondansetron: ☐ 4mg	

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Physician's Phone #	Physician's NPI#	Physician's Fax #	Physician's Address
Dispense as Written	Date	Substitution Allowed	Date

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