Date: _____

Patient Name: _____

Date of Birth: _____

**TwelveStone Health Partners**

**Fax Referral To: (615) 278-3355**

**Direct Phone: (844) 893-0012**

**Email: intake@12stonehealth.com**

# MONOFERRIC ORDER FORM

Allergies: _____ Weight: _____ lbs OR _____ kg

ICD-10 Code:

- ☐ D50.0 Iron deficiency anemia secondary to blood loss (chronic)
- ☐ D50.8 Other iron deficiency anemia
- ☐ D50.9 Iron deficiency anemia, unspecified
- ☐ D63.1 Anemia in chronic kidney disease (Code CKD Stage First)
- ☐ D63.8 Anemia in other chronic diseases (Code underlying disease first)
- ☐ Other: _____

## Therapy Status

*Please select any of the following that apply:*

- ☐ Patient has previously failed oral iron therapy.
- ☐ Patient has previously been treated with Monoferric or other IV iron.
- ☐ Patient has previously experienced an adverse reaction from an iron therapy
- ☐ Patient has chronic renal disease.

## Provider Information

Ordering Provider: _____

Provider NPI: _____

Provider Phone: _____

Provider Fax: _____

Provider Address: _____

## MEDICATION ORDER

| | | | |
|---|---|---|---|
| **Monoferric** | ☐ Patients weighing 50kg or more: Administer Monoferric 1,000mg IV x one dose per protocol.<br>☐ Patients weighing less than 50kg: Administer Monoferric 20mg/kg IV x one dose per protocol. | ✓ Patient will be observed for signs and symptoms of hypersensitivity during infusion and for at least 30 minutes post infusion. | Please include the following lab results required for infusion:<br>✓ ***Hemoglobin and Hematocrit within the past 60 days***<br>✓ ***Iron Studies within the past 60 days*** |

## PRE-MEDICATIONS

***Oral***

- ☐ Acetaminophen: _____ 325mg _____ 500mg _____650mg
- ☐ Loratadine: 10mg
- ☐ Cetirizine: 10mg
- ☐ Diphenhydramine: _____ 25mg _____ 50mg
- ☐ Famotidine: _____ 20mg _____ 40mg
- ☐ Ibuprofen: _____ 200mg _____ 400mg _____ 600mg
- ☐ Ondansetron: _____ 4mg _____ 8mg
- ☐ Other: _____

***IV***

- ☐ Dexamethasone: _____ 4mg _____ 8mg
- ☐ Diphenhydramine: _____ 25mg _____ 50mg
- ☐ Famotidine: _____ 20mg _____ 40mg
- ☐ Methylprednisolone: _____ 125mg
- ☐ Hydrocortisone: _____ 100mg
- ☐ Ondansetron: _____ 4mg _____ 8mg
- ☐ Other: _____

## LAB ORDERS (please indicate any labs to be drawn and frequency)

**Surveillance lab ordering and monitoring is the responsibility of the prescriber**

## OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

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

*By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.*

Dispense as Written:

_____ _____

Prescriber Name Date

Substitution Allowed:

_____ _____

Prescriber Name Date

V 09.18.24