FERINJECT™ (ADULT) ENROLMENT FORM

PATIENT INFORMATION

Patient Name: _____ D.O.B.: Sex: ☐ Male ☐ Female

OHIP #:_____ Cell Phone:_____ Home Phone:_____ Work Phone: _____

Address:_____ City: _____

Province:_____ Postal Code:_____ Email: _____

Allergies:

PRESCRIBER INFORMATION

Prescriber Name: _____ License Number:_____ Phone:_____ Fax:_____

Address: City: Province: Postal Code:

FERINJECT™ Infusion - Adult(18Yrs+) (Max of 15mg/kg or 1000mg per infusion) Weight (IV Therapy) Lbs. Kg

Ferinject in pregnancy can be considered when the mother is 16 weeks and above gestation, and the benefit/risk evaluation has been performed. It is recommended that the maximum cumulative dose in pregnant patients is restricted to 1000 mg for patients with Hb >90 g/L, or 1500 mg in patients with Hb ≤90 g/L. Do not administer more than 1000 mg iron per week.

I confirm the patient is 16+ weeks gestation at time of infusion & risks/benefits have been evaluated.
☐ Yes ☐ No

I confirm the patient is not pregnant at the time of prescribing.
☐ Yes ☐ No

☐ **LU Code 735 (Valid for 1 year)** - For the treatment of patients with iron deficiency anemia (IDA)

☐ **LU Code 736 (Valid for 6 months)** - For the treatment of iron deficiency in patients with heart failure

Hb		Patient Body Weight		
(g/dL)	mmol/L	Below 35 kg	35kg to <70kg	70kg and above
<10	<6.2	500 mg	1500 mg	2000 mg
10 to <14	6.2 to <8.7	500 mg	1000 mg	1500 mg
≥14	≥8.7	500 mg	500 mg	500 mg

Single Dose Infusion (max 1000 mg per sitting)	**Split Dose Infusion (min. 7 days apart)** (max 1000 mg per sitting) 1st Dose: 2nd Dose: # of days between doses:	**No LU Code - not covered by ODB** **Additional Rx / Comments**

PRN Medication	Dose	PRN Medication	Dose
☐ Acetaminophen	325-650mg PO PRN Q 4-6hrs	☐ Hydrocortisone	100mg IV PRN x 1 for severe allergic/anaphylactic reaction
☐ Dimenhydrinate	25-50mg PO/IV PRN q4hrs	☐ Oxygen	via mask/nasal prongs PRN
☐ Diphenhydramine	25-50mg PO/IV/IM PRN q4-6hrs	☐ Ventolin Inh	2 puffs q 4-6hrs via Areochamber
☐ Epinephrine	(1:1000) 0.01 ml/kg (max 0.5ml) SC/IM PRN q 10-15min x 2 for severe anaphylactic reactions	☐ Other:	

PATIENT CONSENT

I hereby authorize Rx Connect Specialty Pharmacy to complete the applicable Patient Support Program enrolment form on my Prescribers behalf. I have read, approved, and consented to the language on the applicable Patient Support Program enrolment form. I authorize Rx Connect Specialty to also obtain medical and personal information from my prescribing physician, pharmacist, nurse, insurer, government agency, employer, or other sources as deemed necessary to ensure the accuracy and completeness of this application and act as a central point of contact for all reimbursement related activities. I confirm that the information I have provided in this application is complete and accurate.

Verbal Consent Attained from the Patient ☐ **YES** ☐ **NO**

Patient Signature **Date (MM/DD/YYYY)**

PHYSICIAN CONSENT

I hereby authorize Rx Connect Specialty Pharmacy to complete the applicable Patient Support Program enrolment form on by behalf, for the above-named patient. I have read, approved, and consented to the language on the applicable Patient Support Program enrolment form. I authorize Rx Connect Specialty Pharmacy to act as my designated Health Case Administrative agent, manage and coordinate all reimbursement related activities, and to forward this prescription above by fax, for the above-named patient This prescription represents the original prescription and there are no others. Any prior prescription(s) for this patient will be cancelled.

Prescriber Name **CPSO #**

Prescriber Signature **Date (MM/DD/YYYY)**

Please forward Prescription to Fax Number: **289.801.7194**

Rx Connect Specialty Pharmacy Inc., 6990 Creditview Road, Unit 4, Mississauga, ON, L5N 8R9, Canada
Phone: 855.MYCARE.8 (855.692.2738) Fax: 289.801.7194 Email: Pharmacy@RxConnect.ca

FERINJECT™ (PEDIATRIC) ENROLMENT FORM

PATIENT INFORMATION

Patient Name: _____ DOB : _____ Sex: Male Female

OHIP #: _____ Cell Phone: _____ Home Phone: _____ Work Phone: _____

Address: _____ City:

Province: _____ Postal Code: _____ Email:

Allergies:

PRESCRIBER INFORMATION

Prescriber Name: _____ License Number: _____ Phone: _____ Fax: _____

Address: City: _____ Province: _____ Postal Code: _____

FERINJECT™ Infusion - Pediatric(1-17Yrs) **(Single administration not to exceed 15mg/kg or 750mg)** Weight (IV Therapy) Lbs. Kg

Ferinject in pregnancy can be considered when the mother is 16 weeks and above gestation, and the benefit/risk evaluation has been performed. The maximum dose in 1 sitting is up to 750mg with a cumulative dose not exceeding those shown in the table below or using the formula provided on the right.

I confirm the patient is 16+ weeks gestation at time of infusion & risks/benefits have been evaluated. Yes No

I confirm the patient is not pregnant at the time of prescribing. Yes No

Calculation of Ferinject dose for pediatric patients (1-17) weighing BELOW 35kg:

Total iron deficit (mg) = - (body weight) kg x (13g/dl – _____ (actual Hb) g/dl) x 2.4 + (15mg x _____ (body weight)kg) = _____ mg

Calculation of Ferinject dose for pediatric patients (1-17) weighing 35kg and ABOVE:

Total iron deficit (mg) = _____ (body weight) kg x (15g/dl – _____ (actual Hb) g/dl) x 2.4 + 500mg = _____ mg

Dose to be infused = _____ mg (please round to nearest 50mg as per product monograph)

Single Dose Infusion (max 750mg per sitting)	Split Dose Infusion (min. 7 days apart) (max 750mg per sitting) 1st Dose: 2nd Dose: # of days between doses:	**No LU Code - not covered by ODB** **Additional Rx / Comments**

PRN Medication	Dose	PRN Medication	Dose
Acetaminophen	325-650mg PO PRN Q 4-6hrs	Hydrocortisone	100mg IV PRN x 1 for severe allergic/anaphylactic reaction
Dimenhydrinate	25-50mg PO/IV PRN q4hrs	Oxygen	via mask/nasal prongs PRN
Diphenhydramine	25-50mg PO/IV/IM PRN q4-6hrs	Ventolin Inh	2 puffs q 4-6hrs via Areochamber
Epinephrine	(1:1000) 0.01 ml/kg (max 0.5ml) SC/IM PRN q 10-15min x 2 for severe anaphylactic reactions	Other:	

PATIENT CONSENT

I hereby authorize Rx Connect Specialty Pharmacy to complete the applicable Patient Support Program enrolment form on my Prescribers behalf. I have read, approved, and consented to the language on the applicable Patient Support Program enrolment form. I authorize Rx Connect Specialty to also obtain medical and personal information from my prescribing physician, pharmacist, nurse, insurer, government agency, employer, or other sources as deemed necessary to ensure the accuracy and completeness of this application and act as a central point of contact for all reimbursement related activities. I confirm that the information I have provided in this application is complete and accurate.

Verbal Consent Attained from the Patient YES NO

Patient Signature **Date (MM/DD/YYYY)**

PHYSICIAN CONSENT

I hereby authorize Rx Connect Specialty Pharmacy to complete the applicable Patient Support Program enrolment form on by behalf, for the above-named patient. I have read, approved, and consented to the language on the applicable Patient Support Program enrolment form. I authorize Rx Connect Specialty Pharmacy to act as my designated Health Case Administrative agent, manage and coordinate all reimbursement related activities, and to forward this prescription above by fax, for the above-named patient This prescription represents the original prescription and there are no others. Any prior prescription(s) for this patient will be cancelled.

Prescriber Name **CPSO #**

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