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

MONOFERRIC™ ENROLMENT FORM

PATIENT INFORMATION

Patient Name:_____ D.O.B.: _____ Sex: ☐ Male ☐ Female Weight (IV Therapy): _____Lbs._____Kg

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

Address: _____ City: _____

Province: _____ Postal Code: _____ Email: _____

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ License Number: _____ Phone: _____

Address: _____ City: _____ Province:_____

Other:

PATIENT REQUIREMENTS

Has the Patient been provided sample product to start? ☐YES ☐ NO

Does the Patient require compassionate product if available? ☐YES ☐ NO

Does the Patient require bridging if available? ☐YES ☐ NO

Biosimilar Transition Support Needed ☐YES ☐ NO

OTHER COMMENTS:

Contraindications:_____

Previous Biologic(s): _____

MONOFERRIC ™	LU	Duration
☐ 1000 mg ☐ 1500 mg ☐ 2000 mg	☐ 610 (IDA)	☐ 3 months ☐ 6 months ☐ Other _____
Additional Rx:	**Other:**	

Hb (g/dL)	Patients with bodyweight <70 kg	Patients with body weight ≥70 kg
≥10	1000 mg	1500 mg
<10	1500 mg	2000 mg

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)**

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