ReGenIV
Restore. Renew. ReGenIV.

REFERRAL & PRESCRIPTION FORM

IV IRON INFUSION • BRITISH COLUMBIA

Fax or email completed form to:
Fax 416-572-8747 | info@regen-iv.com

Referral Date (DD/MM/YY): _____

PATIENT INFO

Patient Name: _____

Address: _____

_____

DOB (DD/MM/YY): _____ Sex: ☐ M ☐ F

Phone: _____ PHN: _____

PROVIDER INFO

Provider Name: _____

College ID: _____

Phone: _____

Fax: _____

Email (optional): _____

Medical Order

Infused as per Product Monograph administration guidelines - infused intravenously for up to 30 minutes.

Body Weight: _____ kg

Monoferric (iron isomaltoside) **Age 18+**
100 mg/mL IV (max dose 20 mg/kg)

- ☐ **500 mg** (Min Wt 25 kg)
- ☐ **1,000 mg** (Min Wt 50 kg)
- ☐ **1,500 mg** (Min Wt 75 kg)

Ferinject (ferric carboxymaltose)
50 mg/mL IV (max dose 15 mg/kg)

- ☐ **500 mg** (Age 12+; Min Wt 34 kg)
- ☐ **1,000 mg** (Age 18+; Min Wt 67 kg)

Is the patient covered by BC PharmaCare? ☐ Yes ☐ No

If yes: ☐ Special Authority form (HLTH 5818) completed and submitted to PharmaCare

Pre-Medication Considerations (select all that apply):

Indication: ☐ Hx of ≥2 drug allergies ☐ Asthma ☐ Prior mild hypersensitivity to IV iron
☐ Inflammatory arthritis ☐ Other: _____

☐ Methylprednisolone (Solu-Medrol) 125 mg IV ☐ Cetirizine 10 mg PO

Prescriber Signature: _____ Date (DD/MM/YY): _____

Quick Facts: Rapid-Access IV Iron Infusions

LOCATION

Pacific Pharmacy #2
11944 88 Ave, Delta, BC V4C 3C8
(Scott Rd & 88 Ave, Surrey/Delta)

COST & COVERAGE

Monoferric & Ferinject covered by most private drug plans
BC PharmaCare: covered with Special Authority approval
$200 suite fee per infusion (may be covered by HSA / extended benefits)

HOW TO REFER

1. Complete this form and fax/email it to us
2. PharmaCare patients: also submit SA (HLTH 5818) via SA eForms
3. We will contact patient to book

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For non-pregnant patients. Follow-up bloodwork recommended 6–8 weeks after infusion.