Perth and Smiths Falls District Hospital

Perth & Smiths Falls District Hospital (Perth Site)
Phone: (613) 267-1500 x 4234
Fax: (613) 267-2041

PATIENT INFORMATION

Allergies: ____________________

Intravenous Iron Replacement (Adult Outpatient) Order Set

ACTION/DATE TIME/INITIALS

Adverse Reactions or intolerances

Drug: ☐ No ☐ Yes (list) ____________________
Food: ☐ No ☐ Yes (list) ____________________
Latex: ☐ No ☐ Yes

Hold IV Iron infusion if temperature is greater than 38°C or if patient is taking PO or IV antibiotics

Indications – All the following criteria must be met

Diagnosis of anemia:

☐ Hemoglobin level less than 120 g/L in females **OR**
☐ Hemoglobin level less than 110 g/L in pregnant woman **OR**
☐ Hemoglobin level less than 130 g/L in males

Hemoglobin: ____________ g/L
Date: _______/______/______

AND
Low iron stores as demonstrated by:

☐ Transferrin/Iron Saturation (TSAT) less than 20%
OR
☐ Ferritin less than 30 mcg/L

TSAT or Iron Sat: ________%
Ferritin: ______________mcg/L
Date: ________/______/______

OR

Any of the following clinical circumstances:

☐ Hemoglobin level less than 80 g/L **OR**
☐ Insufficient time (4 weeks or less) to evaluate efficacy of oral therapy for upcoming procedure (e.g., prior to surgery) **OR**
☐ Documented severe intolerance (e.g., vomiting and/or diarrhea) **OR**
☐ Inadequate response to appropriate trial of oral therapy when taken 1 hour before meals with Vitamin C **OR**
☐ Inability to absorb oral iron (gastric resection or bypass, receiving TPN, other GI disease such as Celiac disease) **OR**
☐ During chemotherapy or radiation therapy for cancer

Monitoring Vitals

☒ HR, RR, BP, SpO_2 prior to infusion and q30 min during infusion
☒ Monitor the patient for at least 30 minutes and until clinically stable post infusion before discharging home

☐ Telephone Order

Ordering Practitioner, Designation	Signature	Date/Time (yyyy/mm/dd hhmm)	☐ Read Back
2nd Check	2nd Check Signature	Date/Time (yyyy/mm/dd hhmm)	☐ Sent to Pharmacy

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Monitoring of pregnant woman

Gestational Age: Weeks ________ Days ____________

*The use of Ferric Derisomaltose (Monoferric™) is contraindicated in pregnancy

Monitoring:

☒ Fetal Heart Rate Doptone prior to iron infusion
☒ Fetal Heart Rate Doptone prior to patient discharge

Drug Coverage Options (Select only one)

The prescriber must provide patient with completed Iron Infusion Prescription for Community Pharmacy form – see Page 6 of this Order Set

☐ Private drug insurance coverage available and applicable for:
- ☐ Ferric Derisomaltose (Monoferric™)
- ☐ Iron Sucrose (e.g., Venofer)
- ☐ Sodium ferric gluconate complex in sucrose (e.g., Ferrlecit®)

☐ Ontario Drug Benefit (ODB) coverage available with following Limited Use (LU) Code for:
The patient must meet the following ODB Limited use Criteria LU Code 610:
Patient has documented diagnosis of Iron Deficiency Anemia confirmed by laboratory testing results AND Patient's Iron Deficiency Anemia has experienced a failure to respond, documented intolerance, or contraindication to an adequate trial of at least one oral iron therapy.
- ☐ Ferric Derisomaltose (Monoferric™)

☐ Ontario Drug Benefit (ODB) Exceptional Access Program (EAP) coverage available for:
N.B. The Prescriber must complete the ODB Exceptional Access Program (EAP) form.
- ☐ Iron Sucrose (e.g., Venofer)

☐ When a patient has NO coverage through (check the box for the patient's situation):
- ☐ Private drug insurance **AND**
- ☐ ODB coverage (LU Code) **AND**
- ☐ ODB EAP coverage **THEN**
- ☐ The prescriber may request the patient's iron infusion supply by completing the PSFDH Non-Funded Drug Request form – see page 5 of this Order Set.

☐ Telephone Order

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Iron Formulations (Select only one) - Patient's weight ____________________ kg

Please complete the Iron Infusion Prescription found on page 6 of this Order Set

☐ Ferric Derisomaltose (Monoferric™)
ODB LU Code 610 if patient qualifies; Contraindicated in pregnancy
Give _____________ mg - maximum single dose up to 20 mg/kg (not to exceed 1,500 mg)
In 0.9% sodium chloride IV over 30 to 60 minutes
On _______/_______/_____ (YYYY/MM/DD) or when possible

☐ Iron Sucrose (e.g., Venofer)
Prescriber to complete application through Special Authorization Information Exchange SADIE found on the **Ministry of Health and Ministry of Long-Term Care web site** www.health.gov.on.ca
Maximum single dose should not exceed 300 mg.
Maximum weekly dose should not exceed 300 mg. Usual maximum total dose of 1,000 mg per course.
Note that rapid administration increases the risk of hypotension.
☐ Iron Sucrose 100 mg (elemental iron) in 100 mL 0.9% sodium chloride IV over 60 minutes.
☐ Iron Sucrose 200 mg (elemental iron) in 100 mL 0.9% sodium chloride IV over 60 minutes
☐ Iron Sucrose 300 mg (elemental iron) in 250 mL 0.9% sodium chloride IV over 120 minutes
☐ Number of doses: _________ Doses to be given ________ days apart
Starting _____/_______/_____ (YYYY/MM/DD) or when possible

☐ Sodium ferric gluconate complex in sucrose (e.g., Ferrlecit®)
Only covered if patient has private insurance or approved by Pharmacy Manager (p. 6 of Order Set)
Maximum of 62.5 mg for the first dose. Maximum of 125 mg for subsequent doses.
Maximum weekly dose should not exceed 375 mg. Usual maximum total dose of 1,000 mg per course
First Dose:
☐ Sodium ferric gluconate complex in sucrose 62.5 mg (elemental iron) in 100 mL 0.9% sodium chloride (0.9% NaCl) IV over 1 hour.

Subsequent doses:
☐ Sodium ferric gluconate complex in sucrose 62.5 mg (elemental iron) 100 mL 0.9% sodium chloride
IV over 1 hour for _________ doses given ________ days apart
Starting _____/_______/_____ (YYYY/MM/DD) or when possible
☐ Sodium ferric gluconate complex in sucrose 125 mg (elemental iron) 100 mL 0.9% sodium chloride IV over 2 hours for ________ doses given ________ days apart,
Starting _____/_______/_____ (YYYY/MM/DD) or when possible

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Infusion Reaction Management

☒ Nurse to monitor for possible infusion reactions, side effects and complications which include the following rash, pruritus, wheezing, dyspnea, dizziness, hypotension, peripheral edema, chest pain or anaphylaxis

- ☒ Stop infusion immediately
- ☒ Apply oxygen supplementation at 35-50% by mask.
- ☒ diphenhydr**AMINE** 25 – 50 mg IV for one dose if patient develops skin rash or wheezing
- ☒ If the patient remains hypotensive, give 500 mL Sodium Chloride 0.9% (NaCl 0.9%) IV bolus
- ☒ Contact prescriber

Qualifier to restart or not Restart – NEEDS FURTHER INFORMATION

Pain/Nausea Management

Pain Management

☒ Acetaminophen 325 – 650 mg PO q 4h prn for pain

Nausea Management

☒ dimenhy**DRINATE** 12.5 – 25 mg PO/IV q4h prn for nausea or vomiting

Additional Orders

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REQUEST FOR COVERAGE UNDER THE PSFDH NON-FUNDED IRON INFUSION PROGRAM

Instructions:
This form is to be completed when requesting intravenous iron infusion therapy for an outpatient in one of the following circumstances (please check as applicable):

☐ Patient cannot tolerate or has failed oral iron therapy and requires intravenous iron therapy
AND
☐ Patient cannot afford the cost of the medication
AND
- ☐ Patient is an Ontario Drug Benefit (ODB) recipient but does not meet the Limited Use criteria for *Ferric Derisomaltose (Monoferric™)* (please describe indication) **OR**
- ☐ Patient is an Ontario Drug Benefit recipient but Exceptional Access Program (EAP) request for iron sucrose has been denied (please attach letter of denial) **OR**
- ☐ Patient does not have a third party insurance (private drug) benefit plan or patient insurance company has denied claim (please attach letter of denial)

☐ **Iron Sucrose (Venofer®)** 100 mg/5 mL, DIN 02243716
- ☐ 100 mg
- ☐ 200 mg
- ☐ 300 mg

Infusion every _______ days (suggested interval of q14days) for ______ doses

Once completed please send this form to the Director of Pharmacy Services for approval and dispensing of the Iron Sucrose vials. Fax number 613-267-9748.

Manager of Pharmacy Services: Approval: ☐ YES ☐ NO

Name. ____________________________ Signature______________________________

Date ____/______/____ (YYYY/MM/DD)

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IV IRON PRESCRIPTION FOR COMMUNITY PHARMACY

Patient Name: ______________________________ Date: _________________

Birthdate______________________

☐ **Iron Derisomaltose (Monoferric®)** 100 mg/mL, DIN 02477777

- ☐ 500 mg
- ☐ 1,000 mg
- ☐ 1,500 mg LUF # ____________
- ☐ _____________

IV for one dose (doses over 1,500 mg must be divided)
For administration at PSFDH Medical Day Unit.
Dispense Vials.

☐ **Iron Sucrose (Venofer®)** 100 mg/5 mL, DIN 02243716

- ☐ 100 mg
- ☐ 200 mg
- ☐ 300 mg

IV q_______ days for ______ doses
For administration at PSFDH Medical Day Unit.
Dispense Vials

☐ **Sodium ferric gluconate (Ferrlecit®) 62.5 mg (elemental iron) vial <u>(not covered by ODB)</u>**
DIN 02243333

- ☐ 62.5 mg for first dose then,
  - ☐ 62.5 mg
  - ☐ 125 mg

IV q_______ days for ______ doses
For administration at PSFDH Medical Day Unit
Dispense Vials

Patient Drug Coverage:

☐ ODB with LUF (Monoferric)
☐ ODB Exceptional Access Program (EAP approval attached) (Iron sucrose)
☐ Third party payer

If Patient drug coverage is denied, please contact the prescriber prior to ordering or dispensing to discuss drug coverage options.

Prescriber Signature________________________________ CPSO#____________

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