



Process for ordering Iron Infusion Therapy:

1. Physician identifies a patient requiring iron therapy.
2. Physician places order depending on the following:
 - a. If **you are a physician with privileges at HHCC**, use the iron therapy order set to record the order for the patient. The form will be available on the form repository site once all approvals have been made. Then proceed to step 3.
 - b. If you are **NOT a physician with privileges at HHCC**, you can either:
 - i. Refer the patient to community infusions clinics in Orangeville, Shelburne and Bolton using the [Ontario Health atHome](#)

***Note:** Ontario Health atHome will accept a referral from ANY physician for appropriate Infusion patients to their Community Clinics.*
 - ii. Contact a physician with privileges at Headwaters (i.e. an Internist or Obstetrician)
3. Iron infusion order set for Headwaters will need to be faxed to Ambulatory Care Booking - 519 941-6022 AND the patient's community pharmacy.

***Note:** Only page one will need to be faxed to the community pharmacy, however, Ambulatory care will need both pages.*
4. Ambulatory Care Bookings will contact the patient and book their infusion date and time.
5. The order set will then be sent to the Ambulatory Care infusion clinic for the nurses to enter the written order as stated on the order set.
6. The patient's community pharmacy will prepare the required iron prescription.
7. The patient will visit the pharmacy on the day of the infusion appointment to pick up the medication.
8. The staff will collect the medication from the patient and prepare the infusion.
9. Patient will receive medication, and documentation will be recorded in Meditech Expanse PCS.

ALLERGIES: _____ ☐ No Known Allergies Height: _____ Weight: _____

Outpatient IV Iron Infusion Order Set

 Fill in the required blanks. Open Box ☐ indicates optional order, activated when checked ☒.

 Checked Box ☒ indicates mandatory order unless crossed out. To delete order, draw line through and initial. Orders not checked will not be implemented.

 Signature, date and time is **REQUIRED**
ACTION

Iron Infusion

☐ **Iron Isomaltoside (Monoferric)**
***** Total Cumulative Dose 1,500 mg in 7 days *****

Dosing Guidelines as per Product Monograph (20 mg/kg body weight):

Hb (g/L)	Weight less than 50 kg	Weight 50 to less than 70 kg	Weight greater than or equal to 70 kg
Greater than or equal 100	500 mg	1,000 mg	1,500 mg
Less than 100	500 mg	1,500 mg	2,000 mg

- ☐ 1,000 mg in 100 mL 0.9% NaCl IV infusion x 1 dose (Infuse over a minimum of 20 minutes)
☐ 1,500 mg in 100 mL 0.9% NaCl IV infusion x 1 dose (Infuse over a minimum of 30 minutes)
☐ 2,000 mg in total given as:
 ☒ 1,000 mg in 100 mL 0.9% NaCl IV infusions x 2 doses given **7 days apart** (infuse each dose over a minimum 60 minutes)
☐ _____ mg in 100 mL 0.9% NaCl IV infusion x 1 dose (infused over a minimum of 60 minutes)
 ☐ Number of repeat doses _____ to be given _____ days apart
Subsequent dosing regimen (specify type of iron, dose and frequency)
☐ _____

OR
☐ **Iron Sucrose**
***** Total Cumulative Dose 1,000 mg in 14 days, max single dose 500 mg*****

- ☐ Iron Sucrose 300 mg in 250 mL 0.9% NaCl over 90 minutes (usual dose)

OR

- ☐ Iron Sucrose _____ mg in _____ mL 0.9% NaCl over _____ hours
 (dose rounded to nearest 100 mg; **dose limit 500 mg/dose**)
☐ Number of repeat doses _____ to be given _____ days apart

OR
☐ **Ferric Carboxymaltose (Ferinject)**
*****Total Cumulative dose 1,000 mg iron per 7 days. *****

Dosing guidelines as per product monograph (15mg/kg of body weight or 1,000mg of total iron)

Hb (g/L)	Weight		
	Less than 35 kg	35 to 70 kg	Greater or equal to 70kg
Less than 100	500 mg	1,500 mg	2,000 mg
100 up to 140	500 mg	1,000 mg	1,500 mg
140 or greater	500 mg	500 mg	500 mg

- ☐ 500 mg in 250 mL 0.9% NaCl IV infusion x 1 dose (infuse over a minimum of 15 minutes)
☐ 1,000 mg in 250 mL 0.9% NaCl IV infusion x 1 dose (infuse over a minimum of 15 minutes)
☐ 1,500 mg in total given as:



ALLERGIES: _____ ☐ No Known Allergies Height: _____ Weight: _____

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☒ 1,000 mg in 250 mL 0.9% NaCl IV infusion x 1 dose (infuse over a minimum of 15 minutes)

then

☒ 500 mg in 250 mL 0.9% NaCl IV infusion x 1 dose **given 7 days apart** (infuse over a minimum of 15 minutes)

☐ 2,000 mg in total given as:

☒ 1,000 mg in 250 mL 0.9% NaCl IV infusion x 1 dose (infuse over a minimum of 15 minutes)

then

☒ 1,000 mg in 250 mL 0.9% NaCl IV infusion x 1 dose **given 7 days apart** (infuse over a minimum of 15 minutes)

Obstetrical population:

*****Total cumulative dose 1,000 mg iron per 7 days. *****

Hb (g/L)	Dose
Greater than 90 g/L	1,000 mg
Equal to or less than 90 g/L	1,500 mg

☐ 1,000 mg in 250 mL 0.9% NaCl IV infusion x 1 dose (infuse over a minimum of 15 minutes)

☐ 1,500 mg in total given as:

☒ 1,000 mg in 250 mL 0.9% NaCl IV infusion x 1 dose (infuse over a minimum of 15 minutes)

then

☒ 500 mg in 250 mL 0.9% NaCl IV infusion x 1 dose **given 7 days apart** (infuse over a minimum of 15 minutes)

☐ Number of repeat doses _____ to be given _____ days apart

Subsequent dosing regimen (specify type of iron, dose and frequency)

☐ _____

Insurance

☐ **Third Party Insurance:**

If the patient has third party coverage for medications, please fax prescription to their preferred pharmacy.

☐ **Ontario Drug Benefit (ODB) program Limited Use (LU) code for ferric derisomaltose (Monoferric) – 610**

Include LU code on the prescription for patients with Iron Deficiency Anemia (IDA) who meet ALL the following Criteria:

- Documented diagnosis of IDA confirmed by laboratory testing.

and

- IDA has experienced failure to respond, documented intolerances, or contraindications to adequate trial (i.e. at least 4 weeks) of at least one oral iron therapy

and

- Patient does not have hemochromatosis or other iron storage disorders

and

- Ferric derisomaltose is administered in a setting where appropriate monitoring and management of hypersensitivity reactions can be provided.



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- ☐ **Ontario Drug Benefit (ODB) program Limited Use (LU) code for Ferric Carboxymaltose (Ferinject)**
- ☐ LU code 735 – include on the prescription for the treatment of patients with iron deficiency anemia (IDA) who meets all the following criteria: **(LU Authorization Period: 1 Year)**
- Patient has documented diagnosis of IDA confirmed by laboratory testing results (e.g. hemoglobin, ferritin)
 - and
 - Patient has experienced a failure to respond, documented intolerance or contraindication to an adequate trial (i.e. at least 4 weeks) of at least one oral iron therapy
 - and
 - Patient does not have hemochromatosis or other iron storage disorders
 - and
 - The iron formulation is administered in a setting where appropriate monitoring and management of hypersensitivity reactions can be provided to the patient.
- ☐ **Ontario Drug Benefit (ODB) program Limited Use (LU) code for Ferric Carboxymaltose (Ferinject) (continued)**
- ☐ LU code 736 – include on prescriptions for the treatment of iron deficiency in patients with heart failure where ALL the following criteria apply: **(LU Authorization Period: 6 Months)**
- Patient is 18 years of age or older
 - and
 - Patient has heart failure with New York Heart Association (NYHA) class II or III
 - and
 - Patient has left ventricular ejection fraction (LVEF) less than or equal to 40% determined by echocardiography
 - and
 - Patient has ferritin level less than or equal to 300mcg/L with a transferrin saturation (TSAT) less than 15%
 - and
 - The iron formulation is prescribed by a cardiologist or prescriber with expertise in the management of chronic heart failure.
- ☐ **Ontario Drug Benefit (ODB) program for Iron Sucrose with Exceptional Access Program (EAP) coverage**
- A Limited Use code for Iron Sucrose is not required for coverage.
 - Physician must fill out [EAP form](#) and fax completed form to EAP Office or call office for verbal approval.
- ☐ **No Insurance**
- ☐ **Fax this Order set to Ambulatory Care Bookings – (519) 941- 6022**
- Provide patient with prescription for IV Iron and instruct to bring medication to appointment
 - Ordering Physician to be available or designate for contact if any adverse reactions occur during administration

Practitioner's Signature _____ Printed Name _____

Date _____ Time _____ (24 hrs)



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Pre-Infusion Lab Results

☐ Hgb _____ ☐ Ferritin _____ ☐ Transferrin saturation _____ Date of lab work results: _____

IV Fluid Therapy

☒ If no existing IV, initiate IV saline lock

Pre-Infusion Medications:

☐ For patients that have had an infusion reaction during a previous IV iron infusion or multiple medication allergies:

☐ Acetaminophen 650 mg PO x 1 dose

☐ Cetirizine 10 mg PO x 1 dose

☐ Hydrocortisone 100mg IV x1

OR
☐ DiphenhydrAMINE _____ mg PO x 1 dose (25-50 mg recommended – oral is preferred route)

☒ Give 30 minutes prior to iron infusion

☐ DiphenhydrAMINE _____ mg IV x 1 dose (25-50 mg recommended)

☒ Give 30 minutes prior to iron infusion

Infusion Reaction Management

☒ Acetaminophen 325 - 650 mg PO PRN q 4 hours for pain, fever or chills (Max 4,000 mg in 24 hours)

☒ Salbutamol MDI 100 mcg/puff – 2 puffs q 4 hours via aero chamber PRN for dyspnea or wheezing

☐ Cetirizine 10 mg PO x 1 dose for itching, urticaria, pruritus, hives

OR
☐ DiphenhydrAMINE 50 mg PO PRN q 4 hours for itching, urticaria, pruritus, hives

☐ DiphenhydrAMINE 50 mg IV PRN q 4 hours for itching, urticaria, pruritus, hives

☒ DimenhydrINATE 25 – 50 mg PO PRN q 4 hours for nausea, vomiting

☒ DimenhydrINATE 25 – 50 mg IV PRN q 4 hours for nausea, vomiting

☐ Other: _____

☒ **Mild hypersensitivity reaction (Fishbone reaction):** itching, flushing, urticaria, sensation of heat, slight chest tightness, hypertension, back/joint pains

☐ Stop iron infusion for 15 minutes or more

☒ Monitor BP, RR, SpO2 x 1 and PRN until stable

☒ When symptoms resolve, restart IV iron at reduced rate of 50% and if tolerating well, complete infusion and observe patient for 60 minutes.

☒ If symptoms reoccur, stop IV iron infusion and inform MD.

☒ **Anaphylaxis:** If patient experiences persistent hypotension (i.e. SBP drop of 30 mmHg from baseline or SBP less than 90mmHg) or angioedema, or involvement of 2 more organ systems (Skin: urticaria, non-airway angioedema; CV: hypotension, chest pain; Respiratory: stridor, bronchospasm, shortness of breath; GI: vomiting, abdominal pain) while receiving the infusion

☒ Stop iron infusion immediately

☒ Notify MRP **STAT**
☒ Keep IV line open with 0.9% NaCl at 30 ml/hr


ACTION

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- ☒ Repeat T, HR, RR, BP, SpO2 x1 and PRN until stable
- ☐ Oxygen via mask/nasal prongs 2 – 5 L/minute PRN for SOB or decreased O2 saturation (below 90% if lower than baseline)
- ☒ EPINEPHrine 0.5 mg IM **STAT** mid-anterolateral thigh x 1 dose
- ☒ If anaphylaxis not resolved, repeat IM EPINEPHrine in 5 minutes x 1 dose
- ☐ Hydrocortisone Sodium Succinate 100 mg IV PRN x 1

Additional Orders:

Practitioner's Signature _____ Printed Name _____

Date _____ Time _____ (24 hrs)

