MARKHAM STOUFFVILLE HOSPITAL CORPORATION

Patient Information stamp will appear here

ACTION

Intravenous Iron Therapy Outpatient Clinic Order Set

Allergies

☐ NKA ☐ Allergies confirmed within Meditech

☐ New Allergies to be entered into Meditech: _____

Criteria for IV Iron

☐ Failed oral iron therapy or unable to take oral therapy

☐ Symptomatic

☐ Evidence of iron deficiency anemia (IDA) (i.e. ferritin less than 10 ug/L or iron less than 10 umol/L; TIBC above upper limit of normal; iron saturation value below lower limit of normal)

Clinic Appointment Booking

☒ Book clinic appointment for initial IV Iron administration

☐ Urgent _____ ☐ Routine _____

☐ Book subsequent clinic appointment

☐ q _____ weeks from initial visit x _____

☐ EAP completed (venofer)

☐ Prescription written [Note: monoferric LU Code 610] (please send copy with this order set to the clinic)

☐ Prescription faxed to retail pharmacy

Lab Investigations

☐ CBC ☐ Iron ☐ Ferritin To be drawn:_____

☐ Other: _____

Monitoring

☒ Observe patient during infusion and for 30 min post infusion for signs of hypotension or hypersensitivity reaction

☒ Temp, HR, RR, BP pre-treatment, post infusion, and after 30 min observation period

IV Therapy

☒ 2/3 – 1/3 or 0.9% Sodium Chloride TKVO. Adjust rate as needed.

Submitter Name:	Date & Time	Order Verified by Signature:	Date & Time
Co-Signer Signature:	Date & Time	Scanner Signature:	Date & Time
		Transcriber Signature:	Date & Time

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Iron Therapy

☐ Iron Sucrose (Venofer) (Patient to supply)

Previous dose received in ED = _____ mg on _____ (date)

☐ (total cumulative dose = 1,000 mg = 2 doses x 300 mg, then 1 dose x 400 mg; account for dose given in Emergency Dept, if applicable). Space doses 2 weeks apart.

Iron Sucrose 300 mg in 250 mL 0.9% Sodium Chloride IV over 2 hours x _____ dose(s) **then**

Iron Sucrose 400 mg in 500 mL 0.9% Sodium Chloride over 3 hours x 1 dose

OR

☐ Iron Sucrose _____

☐ Repeat q 2 weeks from initial visit x _____ **OR** ☐ q _____ weeks from initial visit x _____

OR

☐ Iron Sucrose 200 mg in 100 mL 0.9% Sodium Chloride IV over 1 hour (consider for patients less than 50 kg)

Repeat every 2 weeks x _____ dose(s)

☐ Iron Isomaltoside (Monoferric) (Patient to supply)

Contraindications include but are not limited to: pregnancy, prior allergic reaction to any IV iron product and multiple drug allergies

Hemoglobin (g/L)	Weight less than 50 kg	Weight 50-69 kg	Weight 70 kg or more
Hgb 100 or greater	500 mg	1,000 mg	1,500 mg (give as 1,000 mg then 500 mg 7 days later)
Hgb less than 100	1,000 mg	1,500 mg (give as 1,000 mg then 500 mg 7 days later)	2,000 mg (give as 1,000 mg x 2 doses 7 days apart)

☐ Iron Isomaltoside 1,000 mg in 100 mL 0.9% Sodium Chloride IV x 1 dose. Starting rate 25 mL/h x 5 min then, if tolerated, give remainder over 60 min

☐ Repeat x 1 dose in ☐ 7 days **OR** ☐ _____ days after initial dose (total dose = 2,000 mg)

☐ Iron Isomaltoside 500 mg in 50 mL 0.9% Sodium Chloride IV x 1 dose. Starting rate 25 mL/h x 5 min then, if tolerated, give remainder over 30 min

☐ Repeat x 1 dose in ☐ 7 days **OR** ☐ _____ days after initial dose (total dose = 1,000 mg)

☐ Give x 1 dose in ☐ 7 days **OR** ☐ _____ days after initial 1,000 mg dose (total dose = 1,500 mg)

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Adverse Reaction Management

Avoid use of diphenhydr**AMINE** unless allergic manifestations are present as it may contribute to hypotension in patients with Fishbane reaction

☒ If significant hypotension occurs (BP drop of 25 mmHg or more from pre-treatment value) – stop infusion and notify physician

☐ If signs of anaphylactic reaction (persistent significant hypotension, syncope, urticaria, pruritus, bronchospasm, angioedema) – **STOP** infusion IMMEDIATELY and administer **EPINEPH**rine (1 mg/mL) 0.5 mg = 0.5 mL IM STAT Notify physician STAT.

☐ Acetaminophen 650 mg PO q4h PRN for pain or fever (start 4 hours after premedication dose if given)

☐ Cetirizine 10 mg PO x 1 dose PRN for urticarial/pruritus

☐ dimenhy**DRINATE** 25-50 mg PO/IV q4h PRN for nausea

Other Drug Therapy

Give as premedication only if patient has had previous reaction to IV Iron.

☐ Acetaminophen 650 mg PO x 1 dose PRN

☐ diphenhydr**AMINE** 25 mg IV x 1 dose PRN

☐ Cetirizine 10 mg PO x 1 dose PRN

☐ Famotidine 20 mg PO OR IV x 1 dose PRN

☐ Hydrocortisone 100 mg IV x 1 dose PRN

☐ dimenhy**DRINATE** 25-50 mg PO/IV x 1 dose PRN

Discharge Instructions

Instruct patient to follow up with ☐ Prescribing Physician or ☐ Family Provider

Additional Orders

DO NOT USE: <, >, SC, SQ, SUBQ, U, IU, zero after decimal (write 1 mg) ALWAYS USE: zero before decimal (0.5 mg)

Submitter Name: _____ Date & Time _____ Order Verified by Signature: _____ Date & Time _____

Co-Signer Signature: _____ Date & Time _____ Scanner Signature: _____ Date & Time _____

Transcriber Signature: _____ Date & Time _____