Process for ordering Venofer or Monoferric:

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 <u>NOT</u> a physician with privileges at HHCC**, you can either:

        i. Refer the patient to community infusions clinics in Orangeville, Shelburne and Bolton using the Home and Community Care Support Services Referral

        ***Note**: Home and Community Care 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.

HEADWATERS Health Care Centre
100 Rolling Hills Drive, Orangeville, ON L9W 4X9
T. 519.941.2410 | F. 519.942.0482 | headwatershealth.ca
@HeadwatersHCC

HEADWATERS Health Care Centre

Patient Label

ALLERGIES:_____ ☐ No Known Allergies

Outpatient IV Iron Infusion Order Set

ACTION

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**

Iron Infusion

☐ **Iron Isomaltoside (Monoferric)**

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

Hb (g/dL)	Weight <50 kg	Weight 50 to <70 kg	Weight ≥ 70 kg
≥10 g/dL	500 mg	1 g	1.5 g
<10 g/dL	500 mg	1.5 g	2 g

*****Contraindication: Should not be used during pregnancy based on teratogenicity in animal studies*****

☐ 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 regiment (specify type of iron, dose and frequency)

☐ _____

***** Refer to IV monograph for titration and administration instructions*****

OR

☐ **Iron Sucrose (Venofer®)**

***** 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

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.**

- **Please Note:** A Limited Use code for Venofer is not required for coverage.

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.

☐ **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

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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H.IRONOS

Please fax this order set to Ambulatory Care Bookings – (519) 941-6022

HEADWATERS Health Care Centre

Patient Label

ALLERGIES:_____ ☐ No Known Allergies

Outpatient IV Iron Infusion Order Set	ACTION

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**

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

- ☐ Diphenhydr**AMINE** _____ mg PO x 1 dose (25-50 mg recommended – oral is preferred route)
  - ☒ Give 30 minutes prior to iron infusion
- ☐ Diphenhydr**AMINE** _____ 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 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

☐ Diphenhrydr**AMINE** (Benadryl®) 50 mg PO PRN q 4 hours for itching, urticaria, pruritus, hives
☐ Diphenhrydr**AMINE** (Benadryl®) 50 mg IV PRN q 4 hours for itching, urticaria, pruritus, hives
☒ Dimenhy**DRINATE** (Gravol®) 25 – 50 mg PO PRN q 4 hours for nausea, vomiting
☒ Dimenhy**DRINATE** (Gravol®) 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
- ☒ 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)
- ☒ **EPINEPH**rine (1 mg/ml) 0.5 mg IM **STAT** mid-anterolateral thigh x 1 dose (usual dose 0.01 mg/kg)
- ☒ If anaphylaxis not resolved, repeat IM **EPINEPH**rine in 5 minutes x 1 dose
- ☐ Hydrocortisone Sodium Succinate 100 mg IV PRN x 1

Practitioner's Signature _____ Printed Name_____

Date _____Time_____ (24 hrs)

HHCC-2142 2025/03
H.IRONOS

Please fax this order set to Ambulatory Care Bookings – (519) 941-6022