Brockville General Hospital

INTRAVENOUS IRON REPLACEMENT AMBULATORY PROGRAM ORDER SET

As of June 2025

PATIENT INFORMATION

Allergies: ☐ NKA or _____

Weight (Kg): _____

CRITERIA FOR ADULT OUTPATIENT INTRAVENOUS IRON INFUSION

Choose one of the following (*attach labs if not completed at BGH*):

☐ Documented intolerance/inadequate response to appropriate trial of oral therapy (At least 4 weeks)

OR

☐ Insufficient time (4 weeks or less) to evaluate efficacy of oral therapy prior to upcoming procedure for patients with anemia and iron deficiency as above (e.g. prior to surgery)**.**

Plus 1, 2, OR 3

1. Diagnosis of iron deficiency anemia: Hemoglobin (Hgb) level less than 130 g/L with symptoms (e.g. Fatigue, restless legs). (For pregnant women, refer to Figure 1 on p. 4)
   - ☐ Ferritin less than 50 µg/L.
   - ☐ Transferrin saturation (TSAT) less than 20% (0.20), AND ferritin less than 100 µg/L
2. ☐ **Anemia with chronic kidney disease**: TSAT less than or equal to 30% (0.30) and ferritin less than or equal to 500 µg/L
3. ☐ **Heart Failure patients** (NYHA class II and III, EF less than 40%): TSTAT less than 20%, AND ferritin (ferritin less than 100 µg /L or 100 to 300 µg/L). (Evidence mostly for IV preparation)

PATIENT PRESCRIPTION DRUG COVERAGE

Please check 1, 2, **OR** 3:

1. ☐ Private drug insurance coverage available (Prescriber must provide the patient with a prescription for medication as per order selected below to take to pharmacy)

2. ☐ Ontario Drug Benefit coverage available (Prescriber must provide the patient with a prescription for medication as per order selected below to take to pharmacy) (check box **a** or **b**):
   a. ☐ Iron Sucrose (Ontario Drug Benefit Exceptional Access Program form must be completed by prescriber)
   b. ☐ Ferric Derisomaltose (Patient must meet Ontario Drug Benefit Limited Use Criteria: LU Code 610)

3. ☐ No private drug insurance or Ontario Drug Benefit coverage available. BGH Pharmacy Services to supply intravenous iron (**Iron sucrose or ferric derisomaltose**). (Physician to contact ACU at extension 51251

MEDICATION SUPPLY

Please check 1 OR 2:

1. ☐ Patient will supply iron via prescription
2. ☐ BGH to supply Iron Sucrose or ferric derisomaltose

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MEDICATIONS

Please check 1 **OR** 2, **AND** fill in the blanks:

1. ☐ Ferric derisomaltose (e.g. Monoferric™) in 100mL 0.9% sodium chloride IV over 30 to 60 minutes *(Maximum single dose up to 20 mg/kg body weight)* (check box **a** or **b**):
   a. ☐ 500 mg (elemental iron)
   b. ☐ 1000 mg (elemental iron)

2. Iron Sucrose

   ☐ **Iron sucrose** 300 mg in 250 mL normal saline IV infused over 1.5 hours every ____ days x ____ doses

   OR

   ☐ **Iron sucrose** _____mg IV in normal saline at a max rate of 140 mg/hr every _____ days times _____ doses

Maximum total cumulative dose 1000 mg elemental iron administered in 14 days
Maximum single dose to be given at a time is 500 mg
Patients weighing less than 70 kg may require a longer infusion time
Maximum 6 doses per course/New order will be required each course

MONITORING

☒ Heart Rate (HR), Respiratory Rate (RR), Blood Pressure (BP), Oxygen saturation (SpO_2) prior to infusion, post infusion and PRN

☒ Monitor the patient for signs and symptoms of hypersensitivity for at least 30 minutes and until clinically stable post infusion

INFUSION REACTION MANAGEMENT

*** If symptoms improve within 30 minutes, consider resuming the iron infusion at half the previous rate***
*** If the patient remains hypotensive, consider 500 mL Sodium Chloride 0.9% (NaCl 0.9%) IV bolus. Do not resume the iron infusion***

☒ If the patient develops rash, pruritus, wheezing, dyspnea, dizziness, hypotension, peripheral edema, chest pain or anaphylaxis, stop infusion immediately and contact prescriber

☐ diphenhydrAMINE 25 – 50 mg IV for one dose if patient develops skin rash or wheezing

PAIN/NAUSEA MANAGEMENT

Pain Management

☐ acetaminophen 325 – 650 mg PO q4 h prn for pain

Nausea Management

☐ dimenhyDRINATE 12.5 – 25 mg PO/IV q4 h prn for nausea or vomiting

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ADDITIONAL ORDERS

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Date (yyyy/mm/dd):	**Time:**	**Provider Name (please print):** **Provider Signature:**
Date (yyyy/mm/dd):	**Time:**	**Transcriber Name (please print):** **Transcriber Signature:**

FIGURE 1 - ALGORITHM FOR IRON DEFICIENCY ANEMIA IN PREGNANT WOMEN