Ontario Health atHome

Iron Infusion Order Form

Fax completed form to 1-866-655-6402

Name: _____

Address: _____

Postal Code: _____

Phone: _____

Date of Birth: _____

OHC: _____

Alternate Phone Number: _____

Medical Information

Attention Physicians - The HNHB Service providers are not able to infuse pregnant women or children under 18 with iron d/t their policies and procedures.

Patient Contact Name _____ Contact Phone _____

Weight_____kgs Primary Diagnosis_____

Drug and Other Allergies_____

Order Urgency ☐within next 7 days ☐ 1-2 weeks ☐ 2-4 weeks ☐Other - please specify_____

Iron Therapy Administered in Hospital

Most Recent IV Iron Product Given in Hospital_____ Date_____ (if applicable)

Lab values to be monitored pre and post. Physician to give requisition to patient. Lab work cannot not be done in the nursing clinics. Recommended lab values to be monitored:

- CBC Reticulocytes Ferritin IBC (includes FE, TIBC, TSAT) B12
- Phosphate level if more than one dose Ferric Derisomaltose (FD) is ordered within 3 months to decrease the risk of hypophosphatemia post-infusion

IV Access

☐PIV ☐PORT ☐PICC ☐Central Line ☐Midline Catheter ☐ Tunneled Line

☐ Flush and lock VAD with _____ ml of _____ solution

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Reaction Management Orders - Note only IV orders will be filled by Calea. For all PO orders patients will need to bring their own.

☐ Dimenhydrinate (Gravol®) 25 – 50 mg PO x 1 dose PRN

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☐Cetirizine (Reactine®) 10 – 20 mg PO x 1 dose PRN (do not give if already given as pre-medication)

☐ Acetaminophen Acetaminopen 650 mg PO x 1 dose

☐ 0.9% NaCl at 250 mL IV bolus. Administer as per organization policy and procedure

Pre-Medication

Pre-medication is optional, it is up to the physician if the patient is to take the pre-medication (the infusion is not dependent on the patient taking the pre-meds)

☐As the Community Nursing Clinics do not stock PRN medications, please advise the patients that they are to bring any PO pre-medications that have been recommended for them to their appointment.

☐Acetaminopen 650 mg PO x 1 dose ☐Dimenhydrinate (Gravol®) 25 – 50 mg PO x 1 dose ☐Cetirizine (Reactine®) 10 – 20 mg PO x 1 dose

Physician Name _____	**Date** _____	**Time** _____
Physician Phone/Contact Number: _____		
Physician Signature _____	**CPSO #** _____ **Pager** _____	**Fax** _____

Print Clear

Version 25-001

Patient Name_____ **OHC**_____

Iron Infusion Product

Note - If patient is receiving treatment through Ontario Health atHome the medication will be provided to the patient through Calea. Do **not** have patient pick the medication up from their own pharmacy.

☐Physicians Check the box if you have reviewed the medication benefits and risks with the patient

Iron Sucrose

First dose Iron Sucrose is required in hospital, pending Exceptional Access Program (EAP) approval for remaining doses. Requires EAP approval before Ontario Health atHome Services are initiated. The EAP approval number must be communicated on the referral.

EAP Approval Number_____

☐For the treatment of iron deficiency anemia where the patient has a demonstrated intolerance to oral iron therapy **or** the patient has not responded to adequate therapy with oral iron

☐Completed and signed Order Set & EAP application form fax to Drug Programs Branch 416-327-7526 or 1-888-811-9908

☐**First Dose Form is Completed**(for Ferric Derisomaltose (FD) only) HCCSS HNHB First Dose Form

Iron Sucrose (e.g. Venofer) (EAP Required)

☐Iron sucrose 100 mg IV in NaCL 0.9% over at least 30 minutes_____weekly for max_____ doses

☐Iron sucrose 200 mg IV in NaCl 0.9% over at least 60 minutes_____weekly for max_____ doses

☐Iron sucrose 300 mg IV in NaCl 0.9% over at least 90 minutes_____weekly for max_____ doses

☐Iron sucrose 400 mg IV in NaCl 0.9% over at least 120 minutes_____weekly for max_____ doses

☐Iron sucrose____mg IV in NACl 0.9% over at least____ minutes given as____weeks for_____doses

Bag sizes may change as Calea will determine bag sizes based on stability recommendations

Comments_____

Ferric Derisomaltose (Monofecic)- Limited Use Code 610

☐Ferric derisomaltose 1,000 mg IV in NaCl 0.9% over at least **60** minutes x 1 dose

☐ Ferric derisomaltose 500 mg in NaCl0.9% over **30** minutes x 1 dose

☐Ferric derisomaltose 1,500 mg IV total, given as 1 cycle

- 1,000 mg IV in NaCl 0.9% over at least **60** minutes, followed **minimum of one week later** by
- 500 mg IV in NaCl 0.9% over at least **30** minutes

☐Ferric derisomaltose 2,000 mg IV total, given as:

• 1,000 mg IV in NaCl 0.9% over at least **60** minutes x 2 doses given minimum one week apart

☐Ferric derisomaltose _____ mg IV in NaCl 0.9% qs to 4 mg/ml as per Calea's stability guidelines. Infuse over at least _____ minutes, ____ weeks apart for _____ doses.

All prescriptions must be signed by the ordering physician and faxed to Home and Community Care Support Services. Patients will receive iron infusion in Community Nursing Clinics. If issues arise, the Community Nursing Clinic will contact the ordering physician.

☐Once infusion(s) completed as ordered iron therapy order set is complete and patients iron infusions service can be discharged.

Physician Name _____**Date** _____ **Time** _____
Physician Phone/Contact Number:_____
Physician Signature _____**CPSO #** _____ **Pager** _____ **Fax** _____