

This document is to help guide the use of the provided GRH IV Iron Sucrose package. The documents included in the IV Iron Sucrose Package are:

1. Adult Outpatient Iron Sucrose Order set (page 2 and 3)

Use this document to help determine:

- (1) If the patient is a candidate for IV Iron therapy
- (2) If the IV Iron therapy will be paid for by GRH or by the patient

AND

to order IV Iron Sucrose to be administered at GRH. (Note: if the patient is to pay for the Iron Sucrose they will also require a separate outpatient prescription)

2. Form 1: Facilitating Patient Payment for IV Iron Sucrose (page 4)

This document provides guidance for payment options for patients that have to pay for their own Iron Sucrose.

3. Form 2: IV Iron Sucrose EAP request form (page 5)

This document can be used for patients who are ODB eligible to request Exceptional Access Program Coverage.

We suggest keeping these documents for your records to help you with ordering Iron Sucrose for patient's in the future, however if you need a new package or any of the forms listed above please contact Medical Day Unit at Grand River Hospital at 519-749-4300 ext 2126.

ROUTINE ORDERS
Adult Outpatient Intravenous Iron Order Set

Prescriber instructions: 1) The prescriber MUST check an empty box (☐) to activate the corresponding order. 2) An order with a black box ■ will be activated UNLESS the prescriber crosses out the complete order with a line and initials.					
Date: year/month/day	Time:	Weight (kg): _____ Height (cm): _____	Allergies: ☐ None ☐ Yes Review electronic record	*Order #	Initials
Required Criteria for Outpatient Administration of Intravenous Iron at GRH – Must be complete and attach laboratory reports for 1. and 2. to book appointment.					
All of the following criteria must be met. Check all that apply. <input type="checkbox"/> 1. Diagnosis of iron deficiency anemia: Hemoglobin (Hgb) level less than 120g/L in females or less than 130g/L in males AND <input type="checkbox"/> 2. Low iron stores as demonstrated by: transferrin saturation (TSAT) less than 20% (0.20) AND/OR ferritin less than 15 mcg/L AND <input type="checkbox"/> 3. Insufficient time (4 weeks or less) to evaluate efficacy of oral therapy for upcoming procedure (e.g prior to surgery) OR documented intolerance/inadequate response to appropriate trial of oral therapy OR inability to absorb oral iron					
Eligibility for insured services - Must be complete to book appointment					
<input type="checkbox"/> GRH Pays – intravenous iron will be supplied at the appointment – does not apply to iron isomaltoside. Iron isomaltoside is patient pays only. (IF administration of intravenous iron is an adjunct therapy for an INSURED HOSPITAL SERVICE, such as a surgical procedure, diagnostic test or treatment) Provide details and date:					
<input type="checkbox"/> Patient Pays - patient must bring intravenous iron to appointment (IF sole reason for outpatient visit is intravenous iron administration, even if being treated for iron-deficiency anemia and meets criteria above). Refer patient to GRH Health Care Centre Pharmacy (519-749-4227) to investigate patient funding options. <input type="checkbox"/> Patient has been provided with outpatient prescription for intravenous iron <input type="checkbox"/> EAP application submitted on _____ (date)					
Lab work and Diagnostics					
<input type="checkbox"/> CBC, Ferritin at final scheduled appointment <input type="checkbox"/> Iron Studies at final scheduled appointment					
IV fluid					
<input checked="" type="checkbox"/> Peripheral saline lock, if needed <input checked="" type="checkbox"/> Sodium Chloride 0.9% 250mL at 150mL/hr					
Medication					
Premedication (consider if patient has had reaction during previous iron infusion) <input checked="" type="checkbox"/> DiphenhydrAMINE 50mg IV x 1 ■ prn for reaction ☐ pre infusion <input type="checkbox"/> Hydrocortisone 100mg IV x 1 ☐ prn for reaction ☐ pre infusion <input type="checkbox"/> DimenhyDRINATE 50mg IV x 1 ☐ prn for reaction ☐ pre infusion <input type="checkbox"/> Acetaminophen 1000mg PO x 1 ☐ prn for reaction ☐ pre infusion					
Intravenous Iron – See reverse for dosing. If more than a course of therapy is needed (based on maximum dose), after completion of the course of therapy a new order must be submitted with new blood work meeting the above criteria					
<input type="checkbox"/> Specify type of intravenous iron (iron sucrose or iron gluconate complex): _____ Dose _____mg IV every _____ (frequency) x _____ doses (Maximum 6 doses/course) OR <input type="checkbox"/> Iron isomaltoside (see reverse for dosing chart) total dose per course _____mg (Maximum 1 course per order.) Give iron isomaltoside _____mg IV x 1dose and (if divided dose required) give _____mg IV x 1 dose at least 7 days after the first dose (maximum 1000mg per single dose)					
Monitoring					
<input checked="" type="checkbox"/> Monitor for signs and symptoms of hypersensitivity reactions for at least 30 minutes post infusion and until clinically stable.					

*Enter Order # and initial (by Nurse/Clerical)

Prescriber Signature: _____

Transcriber Signature: _____ Date: _____ Time: _____

Nurse Reviewer Signature: _____ Date: _____ Time: _____



Calculating Iron Replacement Requirements

Normal Hgb; Women: Greater than 120g/L Men: Greater than 130g/L

Hgb deficit (g/L) = target Hgb – actual Hgb

Deficit = _____

Total iron dose required (mg) = (Hgb deficit x 20) + 500

Total Iron requirements= _____

Divide total iron requirement by intravenous iron dose to determine number of infusions.

Intravenous Iron Prescribing Guidelines (See GRH IV manual or Product Monograph for more information)

IV Iron Sucrose (Venofer®)	Administer in divided doses with a preferred maximum daily dose of 300mg and maximum dose of 1000mg in 14 days Maximum course of therapy per order – 6 doses	Dosage regimen once per week but can give multiple doses within a week in certain circumstances (preferable 2 to 3 days between doses) Consider initiating at lower doses for special patient populations such as elderly, pregnant women and renal patients to reduce infusion reactions		
IV Iron Gluconate Complex (Ferrlecit®)	Administer in divided doses of 125mg elemental iron. Maximum recommended single dose: 250mg Maximum course of therapy per order – 6 doses			
Iron Isomaltoside (Monoferric®)	Hemoglobin (g/L)	Total Iron Dose – Maximum dose per course of therapy per order		
		Body weight less than 50kg	Body weight 50 to 69 kg	Body weight 70kg or greater
	100 or greater	500mg	1000mg	1500mg (given in 2 divided doses of 1000mg + 500mg 7 days apart)
	Less than 100	1000mg (given in 2 divided doses of 500mg + 500mg 7 days apart)	1500mg (given in 2 divided doses of 1000mg + 500mg 7 days apart)	2000mg (given in 2 divided doses of 1000mg + 1000mg 7 days apart)

Guidance for outpatient prescription

When providing an outpatient prescription please include as follows:

Intravenous type/brand _____ Dose _____ mg (dose) every _____ (frequency) x _____ (number of doses)

Form 1: Facilitating Patient Payment for IV Iron Sucrose

For patients obtaining their own supply of IV Iron Sucrose (Venofer) for administration at the Medical Day Unit at Grand River Hospital there are 4 potential options. See below for pricing and information regarding Health Care Centre Pharmacy dispensing.

1. Private insurance

Patients contact their private insurance provider to determine if they are eligible to have IV Iron Sucrose dispensed through their plan. The patient must do this on their own, but may need the drug identification number listed here (DIN: 02243716).

2. Exceptional Access Coverage

Physicians can apply for exceptional access for all ODB patients (including those on Trillium) for IV iron sucrose therapy. The Exceptional Access Form (Form 2) has been attached or can also be accessed from the Medical Day Unit at Grand River Hospital.

3. Patients pay cash

Patients can pay cash at their own community pharmacy or Health Care Centre Pharmacy at the hospital for their IV iron and pick the dose up prior to their scheduled appointment.

4. Special considerations

For patients that don't have private or EAP coverage but who are unable to afford their IV iron, we will discuss these cases on an individual basis to determine the best course of action. Please contact the Clinical Manager, Medical Day Unit; 519-749-4300 ext 3956.

Health Care Centre Pharmacy Information

Cost per dose of medication for cash paying patients (prices are subject to change)

Dose	Approximate Cost
100mg	\$53.00
200mg	\$96.00
300mg	\$140.00
400mg	\$183.00
500mg	\$227.00

Reasons to use HCCP for IV Iron

- Convenience – pick up your Iron on the way to your appointment
- Supply – HCCP will always have supply of IV Iron available for our Medical Day Unit Patients
- Quick and friendly service – HCCP will only need 30 minute notice to fill your IV Iron prescription

FORM 2: IV iron sucrose EAP request form

To be completed and submitted for Ontario Drug Benefit (ODB) patients (e.g. over 65 years, on social assistance, or covered through Trillium Drug Program)

Exceptional Access Program (EAP) Request for Iron Sucrose (Venofer) for the Treatment of Iron-Deficiency Anemia

Fax the completed form and/or any additional relevant information to (416) 327-7526 or toll free to 1-866-811-9908; OR send to EAPB Ontario Public Drug Programs, Exceptional Access Program Branch, 3rd Floor, 5700 Yonge Street, Toronto, ON, M2M 4K5

Section 1 – Prescriber Information			Section 2 – Patient Information		
First name	Initial	Last name	First name	Initial	Last name
Mailing Address			Health Number		
Street no.		Street name			
City		Postal code			
Fax no. ()		Telephone no. ()	Date of birth (yyyy/mm/dd)		

New request **Renewal of existing EAP approval** (specify EAP#) _____

Section 3 – Drug, Dose and Regimen Requested

Drug product: Iron sucrose (Venofer) 100mg/5mL vial(s)
 Dose: _____
 Frequency: _____
 Number of doses: _____

Section 4 – Laboratory Results (Attach a copy of the results or submit the following results indicated below)

Diagnosis of iron-deficiency anemia has been confirmed with documented bloodwork
 Hemoglobin: _____ g/L MCV: _____ fL Date collected: _____
 If Hemoglobin less than 120 g/L in females or less than 130 g/L in males or MCV less than 75fL or greater than 120fL, provide the following:

Date Drawn	Level	Date Drawn	Level
	Ferritin		Serum Iron Levels
	mcg/L		mcg/dL
	TSAT		Total iron binding capacity (TIBC)
	%		mcg/dL

Section 5 – Medication: Current and/or Previous

Patient has already been treated with at least one iron product as summarized below:

Medication and Name	Dose	Start Date	Duration
Oral Iron			
Oral Iron			
IV Iron			

AND
 Patient has demonstrated intolerance to oral iron therapy
 OR
 Patient has not responded to an adequate therapy with oral iron

The information on this form is collected under the authority of the *Personal Health Information Protection Act, 2001, S. O. 2001, c.3, Sched. A (PHIPA)* and Section 13 of the *Ontario Drug Benefit Act, R. S. O. 1990c.O.10* and will be used in accordance with PHIPA, as set out in the Ministry of Health and Long-Term Care "Statement of Information Practices", which may be accessed at www.health.gov.on.ca If you have any questions about the collection or use of this information, call the Ontario Drug Benefit (ODB) Help Desk at 1800-668-6641 or contact the Director, Exceptional Access program Branch (EAPB), Ministry of Health and Long-Term Care, 3rd floor, 5700 Yonge St., Toronto, Ontario M2M 4K5 \

Prescriber signature (mandatory)	CPSO number	Date
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