GRAND RIVER HOSPITAL
Advancing Exceptional Care

This document is to help guide the use of the provided GRH IV Iron 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 to be administered at GRH. (Note: if the patient is to pay for the IV Iron they will also require a separate outpatient prescription)

2. **Form 1: Facilitating Patient Payment for IV Iron (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 IV Iron 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.

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Patient Identification Sticker

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.
☐ 1. Diagnosis of iron deficiency anemia: Hemoglobin (Hgb) level less than 120g/L in females or less than 130g/L in males **AND**
☐ 2. Low iron stores as demonstrated by: transferrin saturation (TSAT) less than 20% (0.20) AND/OR ferritin less than 15 mcg/L **AND**
☐ 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

☐ **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:_____

☐ **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.
☐ Patient has been provided with outpatient prescription for intravenous iron
☐ EAP application submitted on_____ (date)

Lab work and Diagnostics

☐ CBC, Ferritin at final scheduled appointment
☐ Iron Studies at final scheduled appointment

IV fluid

■ Peripheral saline lock, if needed
■ Sodium Chloride 0.9% 250mL at 150mL/hr

Medication

Premedication (consider if patient has had reaction during previous iron infusion)

■ DiphenhydrAMINE 50mg IV x 1	■ prn for reaction	☐ pre infusion
☐ Hydrocortisone 100mg IV x 1	☐ prn for reaction	☐ pre infusion
☐ DimenhyDRINATE 50mg IV x 1	☐ prn for reaction	☐ pre infusion
☐ 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

☐ Specify type of intravenous iron (**iron sucrose or iron gluconate complex**):_____
Dose _____mg IV every _____ (frequency) x _____ doses (Maximum 6 doses/course) **OR**
☐ **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

■ 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:_____

See Over →

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

For patients obtaining their own supply of IV Iron 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 dispensed through their plan. The patient must do this on their own, but may need the drug identification number listed here
   Iron Sucrose DIN: 02243716
   Iron Isomaltoside DIN: 02477777

2. **Exceptional Access Coverage – Only avaible for IV Iron Sucrose**
   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)

Iron Sucrose (Venofer) Dose	**Approximate Cost**
100mg	$53
200mg	$96
300mg	$140
400mg	$183
500mg	$227

Iron Isomaltoside (Monoferric)	**Approximate Cost**
500mg	$274
1000mg	$535

- Monoferric requires fewer visits to infuse the same amount of iron.
- Most private drug plans currently cover Monoferric without any prior authorization requirement

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 Street no. | Street name			Health Number		
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	mcg/L		Serum Iron Levels	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 ww.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