Alberta Health Services

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X)		

Iron Ferric Derisomaltose (Adult) Recurrent Treatment

This form is intended for submitting treatment requests to hospital Day Medicine departments.

Note: As part of a pilot project, only **Red Deer Regional Hospital Centre Day Medicine** is currently set up to receive referrals through this process.

Referrals may be submitted by **physicians with admitting privileges at Red Deer Hospital,** with or without Connect Care access. All referring prescribers must include current telephone contact information and remain available to Day Medicine staff during regular business hours.

Treatment Requirements

Type of Treatment ☐ New ☐ Renewal

Consent for Treatment - Required	☐ Attached	Past Medical History - Required	☐ Attached
Current Medications - Required	☐ Attached	Relevant Blood Work *Blood work must be within 1 month of referral except Type and Screen which must be within 96 hours*	☐ Attached

Allergies ☐ No Known Allergies

Goals of Care Designation

☐ R1 ☐ R2 ☐ R3 ☐ M1 ☐ M2 ☐ C1 ☐ C2

Confirm Indication for Treatment

Low ferritin, and **at least 1** of the following: (choose at least one)

- ☐ symptomatic *(dyspnea, chest pain, lightheaded, syncope, ongoing bleeding)*
- ☐ asymptomatic but with Hgb less than 80g/l
- ☐ failure to respond to adequate trial of oral iron *(specify types and duration of therapy trailed)* _____
- ☐ known to have malabsorption

Low ferritin

15 yrs. or greater:
- *Male ferritin less than 30 mcg/l*
- *Females less than 20mcg/l.*

Under 15 yrs.:
- *ferritin less than 15 mcg/l*

Appointment Request

☑ Infusion Appointment Request: ☐ Once ☐ Every _____ weeks for _____ treatments

Labs

Referring provider is responsible for ordering and managing all relevant Lab tests *(such as CBC with Differential, Reticulocyte Count, Ferritin, Iron/TIBC, Phosphate)*

Patient Care Orders

☑ Nursing Communication

Monitor for Fishbane reaction: Transient flushing, back and chest tightness/pain with joint pains.

- Stop infusion immediately, assess patient symptoms and vital signs.
- Observe patient for the next 5-10 minutes, do not treat if only mild symptoms.
- If symptoms subside restart infusion at half the starting rate; if symptoms worsen and/or patient becomes hypotensive then follow Anaphylaxis protocol.
- Notify attending physician for any concerns.

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Patient Care Orders continued

☑ Nursing Communication

Anaphylaxis Protocol for Iron Infusions

- Stop infusion. Switch IV iron tubing to IV NaCl 0.9% and administer NaCl 0.9% as fast as possible, if clinically appropriate
- Administer IM EPINEPHrine 0.3 mg to mid anterior lateral thigh. Repeat dose PRN every 5 minutes to a maximum of 3 doses.
- Notify attending physician

☑ Nursing Communication

- Monitor for hypersensitivity reactions, including BP, at baseline, then every 15 to 30 minutes during the infusion, and for 30 minutes after the end of the infusion, or until clinically stable.

☑ Nursing Communication

- Monitor IV site for symptoms of extravasation.
- If extravasation occurs: Stop the IV, aspirate as much drug as possible and remove the needle/ catheter if peripheral.
- Apply cold compresses to affected area and elevate limb. Do not massage the area.

☑ Nursing Communication

- Observe for 30 minutes after infusion for delayed reaction: backache, muscle pains, chills, dizziness, fever, headache, nausea and/or vomiting.
- Educate Patient that reactions may occur 24 to 48 hours after onset of infusion and usually subside in 3 to 7 days.

Pre-Medications

☐ methlyPREDNISolone 40mg IV PRN, 30 minutes prior

Infusion

☑ Vital Signs – per protocol

☐ Ferric-Derisomaltose 1000 mg IV Every _____ Weeks – Greater than 50kg

☐ Ferric-Derisomaltose 500 mg IV Every _____ Weeks – Less than 50kg

Provider Communication -

☑ Doses of up to 1500 mg may be given in one session. If greater than 1500 mg, the dose should be divided and administered over multiple sessions.

Emergency Medications

☑ Epinephrine 1 mg/mL, 0.3 mg intramuscular, Once, as needed for anaphylaxis. Administer to mid-anterior lateral thigh (vastus lateralis muscle).

If the patient does not improve, repeat dose every 5 minutes up to a maximum of 3 doses.

☑ Acetaminophen 650 PO, Once, as needed; temp greater than 37.5 C - infusion reaction

☑ cetitizine tablet 20 mg PO, Once, as needed - Infusion reaction

☑ methlyPREDNISolone sodium succinate 125 mg IV, Once, as needed – infusion reaction

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Emergency Medications continued

☑ NaCl 0.9%bag 500 mL, IV, administer over 10 minutes, as needed – hypotension

☑ Salbutamol 100 mcg/actuation inhaler 2 to 4 puffs, once, as needed via spacer recommended – bronchospasms. Repeat every 20 mins as required

☐ Hydrocortisone sodium succinate 100mg IV, Once, as needed for treatment of pruritis, urticaria and rash only if patient is unable to take cetirizine 20 mg orally – infusion reaction

☐ dimenhyDRINATE 50 mg IV, Once, as needed – infusion reaction

☐ diphenhydrAMINE 50mg IV, Once, as needed for nausea and vomiting - infusion reaction

Name MRHP	Designation	
Phone	Fax	Pager / Cell Phone
Signature		Date *(dd-Mon-yyyy)*

Additional Patient Information

Name of Caregiver/Guardian/Alternate Decision Maker	Relationship	Phone

Interpreter Required ☐ No ☐ Yes ► Specify Language _____

Special Considerations for Care