Salisbury NHS Foundation Trust

Ferinject® for Maternity patients prescription form

Patient details label

Date _____ Patient's consultant _____

Gestation_____ **OR** If post-partum tick here ☐

Booking Weight (kg) _____ Current Hb level (g/l) _____

ALLERGIES:

_____

Prescriber's checklist:

1. Ferinject is indicated when ALL the following are true:

   a. Patient is more than 14 weeks gestation and has an Hb of <80g/L, is >34 weeks/post-partum and Hb <100g/L **OR:** ☐

   b. The patient has iron deficiency anaemia* and has not responded or tolerated oral iron[ł] OR needs rapid increase in iron stores OR has an iron functional deficiency. ☐

   c. The patient consents to intravenous iron and has signed the form ☐

   d. The risks and side effects have been discussed with the patient ☐

   e. The patient has a copy of the information leaflet ☐

*Confirmed by ferritin levels < 30µg/L with microcytic or normocytic anaemia, and no haemoglobinopathy

łA rise in Hb should be demonstrable by 2 weeks after commencing oral iron and confirms iron deficiency anaemia[1]

2. Ferinject is NOT contraindicated according to the SOP ☐

3. Side effects and follow up has been discussed with the patient ☐

Ferinject® dose calculation table:

- The figure in the box represents the dose of IV iron (Ferinject®) required in mg.
- Ferinject® may be administered by intravenous infusion up to a maximum single dose of 1000 mg of iron or not exceeding 20 mg/kg body weight.
- The recommended doses and numbers of infusions are shown in the table below.
- Multiple infusions must have a dosing interval of 7 days.
- For some clinical circumstances a clinician may decide to administer fewer infusions but the doses must not exceed those stated below.

Weight	Current Haemoglobin (g/l)		
	<100	**100-<140**	**≥140**
35 kg- <50kg	1500 mg total (As three 500 mg infusions)	1000 mg (As two 500 mg infusions)	500 mg
50-<70kg	1500 mg total (As one 1000 mg and one 500 mg infusion)	1000 mg (As a single infusion)	500 mg
≥ 70 kg	2000 mg total (As two 1000 mg infusions)	1500 mg (As one 1000 mg and one 500 mg infusion)	500 mg

For inpatients, prescribe Ferinject on ePMA. For outpatients, use the below form. Inform pharmacy once prescribed to organise supply.

OUTPATIENT PRESCRIPTION FORM FOR DAU (for inpatients prescribe on ePMA):

TOTAL DOSE OF IV IRON (Ferinject®) = ……..….mg to be administered over …….infusion(s).

Planned infusion dates	Ferinject® dose	Infusion duration and Sodium Chloride 0.9% volume	Administered by / date	Pharmacy
Infusion 1:	**…….mg**	**□ 250 ml over 15 mins** **□ 100 ml over 6 mins$**		
Infusion 2: (if required)	**…….mg**	**□ 250 ml over 15 mins** **□ 100 ml over 6 mins$**		
Infusion 3: (if required)	**…….mg**	**□ 250 ml over 15 mins** **□ 100 ml over 6 mins$** **$ - 500mg doses only**		

Prescribers Signature ……. Bleep: …….. Date: …….

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Maternity Patient consent form for Ferinject

A copy of this form should be filed in the patient's notes.

Patient name label

This patient is receiving Ferinject on:

Infusion 1 date: …….

Infusion 2 date (if applicable): …….

Infusion 3 date (if applicable): …….

Patient consent:

I acknowledge and understand that the proposed treatment of an intravenous iron infusion(s) with the above product has been explained to me and is to be performed on me, the patient:

- The benefits and risks of having intravenous iron have been explained to me
- Side effects have been explained to me
- The potential alternatives to intravenous iron (blood transfusion or oral iron therapy) have been offered (if appropriate) and explained to me.
- I have been given a copy of the patient information leaflet about intravenous iron
- I understand to stop any oral iron therapy for 5 days after the infusion
- I have been given the opportunity to ask questions about the treatment
- I understand I can withdraw my consent at any time

Patient name: …….

Patient signature: ……. Date: …….