NHS
Salisbury
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Cosmofer® 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. Cosmofer is indicated when ALL the following are true:

   a. Ferinject is contraindicated ☐

   b. Patient is more than 14 weeks gestation and Hb <80g/L **OR** is >34 weeks/post-partum and Hb <100g/L ☐

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

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

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

   f. 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. Cosmofer is NOT contraindicated according to the SOP ☐

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

Cosmofer® dose calculation table:

- Cross reference booking weight (use ideal body weight if >90kg) with current haemoglobin level.
- The figure in the box represents the dose of IV iron (Cosmofer®) required in mg.
- If this dose is in a shaded box, then the dose must be divided into two infusions given at weekly intervals as it is above the upper limit for a single infusion. Maximum dose of iron per infusion is 20mg/kg body weight. You can consider using the next lowest single administration dose.

Table for target Hb 110 g/l					
Booking Weight (kg)	**Current Haemoglobin (g/l)**				
	60	70	80	90	100
35	900	825	750	650	575
40	975	875	775	675	575
45	1025	925	800	700	600
50	1100	975	850	725	600
55	1150	1025	875	750	625
60	1200	1075	925	775	625
65	1275	1100	950	800	650
70	1325	1150	1000	825	650
75	1400	1200	1025	850	675
80	1450	1250	1075	875	675
85	1500	1300	1100	900	700
90	1575	1350	1125	925	700

PRESCRIPTION FORM:

If the first infusion is to be given as an inpatient, please also prescribe on ePMA. Please ensure to liaise with DAU/Nunton Unit if doses will be given as outpatient care.

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

Planned infusion dates	**Cosmofer® dose to be administered**	**Volume to be given over 15 minutes initially**	**Pharmacy**	**Administered by / date / location**
Infusion 1:	..............**mg**	**(500ml ÷ dose of Cosmofer mg) x 25mg** **= .... millilitres**		
Infusion 2: (if required after 7 days)	...……..**mg**	**(500ml ÷ dose of Cosmofer mg) x 25mg** **= ………… millilitres**		

Signature of prescriber: …………………………………..   Bleep:…………………   Date:………………

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Maternity Patient consent form for Cosmofer

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

Patient name label

This patient is receiving Cosmofer on:

Infusion 1 date: ………………….

Infusion 2 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: …………………….