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 **OR** is >34 weeks/post-partum and Hb <100g/L ☐

   b. The patient has iron deficiency anaemia* and has <u>not</u> 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

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 (Ferinject®) = ……..….mg to be administered over …….infusion(s).

Planned infusion dates	Ferinject® dose	Infusion duration and Sodium Chloride 0.9% volume	Administered by / date / location	Pharmacy
Infusion 1:	**…….mg**	**□ 250 ml over 15 mins** **□ 100 ml over 6 mins$**		
Infusion 2: (if required, after 7 days)	**…….mg**	**□ 250 ml over 15 mins** **□ 100 ml over 6 mins$**		
Infusion 3: (if required, after 7 days)	**…….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: …….