Authorisation Form for Administration of IV Infusion Iron Therapy (Ferinject®)

Somerset Partnership NHS
NHS Foundation Trust

Referrer to complete in full section in BLUE and RED. **Original MUST be received by the ambulatory Care Unit before the patient can receive treatment**
Green section to be completed by ambulatory care unit.

Patient Addressograph

First name: ..... **Ambulatory Care Unit:** ....

Surname: .....

NHS Number: ..... **D.O.B:** .....

ALLERGIES:

Dosing Information

Base line weight (Kg): .....

Date weighed: .....

Actual Hb:
HB (g/dL): ....
or
Hb (mmol/L): .....

Date Hb bloods taken: ... .

Weight:
- Dose for patients with weight ≥50kg = 1000mg
- Dose for patients <50kg = max of 20mg/kg Ferinject® - please use alternate authorisation form

Maximum weekly dose:
- Do not administer more than 1000mg Ferinject® per week.
- Haemodialysis patients should receive no more than 200mg of Ferinject ®per week – please use alternative authorisation form

Haemoglobin >14 g/dL or >8.7 mmol/L:
- Dose should not exceed 500mg –IV iron therapy not routinely required.

Authorisation & Administration

Drug / Fluid	Dose Volume	Route	Infusion time / Bolus	Authorisation to administer: Name	Signature	Date authorisation written*	Administration: Complete nurse care plan before administration	Batch number / Expiry date	Time given / begun	Prepared by / Checked by
Sodium chloride 0.9%	10ml	IV flush	Bolus							
Ferinject®	1000mg	IV infusion	Over 60 minutes							
Sodium chloride 0.9%	100ml									
Sodium chloride 0.9%	Up to 20ml	IV flush	Bolus							

***Authorisation to administer expires 28 days from date of authorisation date.**

Clinical referral criteria

Diagnosis (please tick as appropriate):

- ☐ Iron deficient anaemia based on lab tests

Indication (please tick):

- ☐ intolerance of oral iron preparations
- ☐ demonstrated lack of effect of oral iron preparations
- ☐ where there is a clinical need to deliver iron rapidly to iron stores
- ☐ other. Please specify:
- ☐

……

Prescribing Guidance Compliance (please tick):

- ☐ This prescribing meets my organisation formulary requirements
- ☐ This prescribing meets my organisation guidelines for prescribing Ferinject®

Patient History (please tick):

- ☐ I have undertaken a thorough patient assessment and medical history relating to IV Iron therapy
- ☐ The patient has no contraindications to Ferinject®
  Contraindications include:
  - hypersensitivity to active substance or any of its excipients
  - known serious hypersensitivity to other parenteral iron products
  - anaemia not attributable to iron deficiency e.g. microcytic anaemia
  - evidence of iron overload or disturbances in the utilisation of iron.
- ☐ The patient is not known to have the following conditions:
  - Drug allergies, history of severe asthma, eczema or other atopic allergy

Comment: ……

Follow up

Clinician responsible for patient follow up: ……

Address ……

Phone number: …… E-mail : ……

Note: HB level should be reassessed no earlier than 4 weeks post final Ferinject administration.

Medication Supply

Ferinject® is provided by the ambulatory care unit. Costs are reclaimed through the CCG.

Flushes and infusion fluids are provided by the ambulatory care unit. Costs are reclaimed through the CCG

Discharge

- ☐ A patient information leaflet on Ferinject ® has been provided to the patient (https://www.medicines.org.uk/emc/PIL.24901.latest.pdf)
- ☐ The patient has been informed that oral iron therapy if required should not be started or continued for at least 5 days following IV iron therapy.
- ☐ A standard discharge letter has been provided to the patient
- ☐ A standard discharge letter has been provided to the GP
- ☐ A standard discharge letter has been provided to the clinician responsible for patient follow up as requested above

Frome ACU: Phone: 01373 454799 Fax: 01373 454781
Wiliton ACU: Phone: 0300 124 5607 Fax: 01934 635646
Shepton ACU: Phone: 01749 341104 Fax: 01749 341133
Bridgwater ACU: Phone: 0300 124 5601 Fax: 01278 721635

June 2019