

EMERGENCY ANTIDOTAL MANAGEMENT OF POISONINGS



This educational poster is not intended for individual patient care. Information is believed accurate as of 09/2023.

If you are caring for a known or suspected toxic exposure patient, please call your poison center (1-800-222-1222) for patient specific management advice and assistance with locating antidotes.

Poison/Condition	Antidote	Minimum Stocking Level A	Dose	Comments
Acetaminophen	Acetylcysteine for IV use (Acetadote®)	120 g* = 20 vials [30 mL vials (200 mg/mL) x	150 mg/kg IV over 1 hr, then 12.5 mg/kg for 4 hr, then 6.25 mg/kg/hr for 16 hr	Generally preferred over oral NAC, Both IV and PO are most effective if initiated within 8 hours of acute ingestion. May be of value
ленинориян	, , , , , , , , , , , , , , , , , , , ,	20] for 4 patients x 24 hr	or until APAP < 10 and liver enzymes normal or improving.	even in late presenters. Administration protocols may vary. Continue beyond 21 hr if acetaminophen level remains elevated or
			Higher doses may be needed.	worsening liver injury. Fomepizole may be helpful with severe overdoses. Call PC for case-specific advice.
	N-acetylcysteine (NAC; Mucomyst8)	54 g [30 mL 20% sol. vials x 9]	Loading Dose: 140 mg/kg PO; Maintenance Dose: 70 mg/kg q 4 hr PO x 5 doses. May require antiemetic for first few doses.	Duration may be extended beyond 24 hr, depending on clinical situation. Contact PC for case-specific dosing advice.
Anticholinergics	Physostigmine (Antilirium®)	4 mg* [2 mL vials (1 mg/mL) x 2]	1.5-2 mg IV (adult); 0.02 mg/kg IV (child, max 0.5 mg) diluted in 10 mL 0.9%	Physostigmine may cause seizures or life-threatening arrhythmias (if used in tricyclic antidepressant overdose with QRS widening
			saline over 5 min.	or bradycardia). Physostigmine is currently unavailable; rivastigmine 3 mg PO along with a transdermal patch may be used as an
Anticoagulant Therapies:	Idarucizumab (Praxbind®)	5 g (2 vials, each contains 2.5 g/50 mL vial)	5 o IV (2 vials, each contains 2.5 o) as two consecutive influsions or holes by	alternative, Contact PC for guidance. Do not mix with other medicinal products. A pre-existing IV line may be used, but the line must be flushed with 0.9% saline prior to
Dabigatran	(Flatonos)	o g (z mas, each contains 2.0 g oo mc mag	injecting one vial after another.	Infusion. No other infusion should be administered in parallel via the same IV access.
	Andexanet Alfa (Andexxa®)	1800 mg [100 mg vials x 18]	LOW DOSE: Initial: 400 mg IV bolus at a target rate of 30 mg/min followed by	Dosing is dependent on the specific FXa inhibitor, dose of FXa inhibitor, and time since the patient's last dose of FXa inhibitor.
Factor Xa Inhibitors, e.g.,	, , , , , , , , , , , , , , , , , , , ,		4 mg/min for up to 120 min. HIGH DOSE: Initial: 800 mg IV at a target rate of	Contact PC for case-specific dosing advice. Monitor for possible thromboembolic, ischemic and/or cardiac events that may develop
Apixaban, Rivaroxaban			30 mg/min followed by 8 mg/min for up to 120 min.	following the use of this reversal agent. Inform patients these events may be delayed.
	Protamine sulfate	1.2 g*		High doses and rapid administration may result in severe hypotension, cardiovascular collapse, pulmonary edema, and pulmonary
Heparin			as 50 mg (10 mg/mL, 5 mL) and 250 mg (10 mg/mL, 25 mL), for IV use only.	hypertension. Do not administer with other medications without ensuring compatibility.
	Phytonadione (Vitamin K1)	200 mg* [10 mg/1 mL, 1 mL vials x 20]	Dose varies by heparin type. Protamine sulfate single dose vials are available	Do not use Vitamin K1 prophylactically with normal PT/INR. If active bleeding, also administer fresh frozen plasma.
Warfarin/Superwarfarins			as 50 mg (10 mg/mL, 5 mL) and 250 mg (10 mg/mL, 25 mL), for IV use only.	
Benzodiazepines	Flumazenii (Romazicon®)	4 mg (1 mg/vial x 4)	Adult: 0.2 mg IV to total dose max 3 mg; Child: 0.01 mg/kg IV to total dose	Contraindicated in benzodiazepine-dependent patients, poly-drug overdoses and unknown ingestions due to risk of seizures. Can
	NOT RECOMMENDED FOR OVERDOSE PATIENTS		max 3 mg FOR IATROGENIC OVERDOSE ONLY.	almost always manage benzodiazepine exposure with supportive care.
	Glucagon	240 mg* [1 mg/vial x 240 vials]	50-100 mcg/kg IV bolus. If response, start 50 to 100 mcg/kg/hr infusion.	Continuous ECG monitoring. May cause nausea/vomiting. Phenol diluent should not be used for preparing infusion.
Calcium Channel Blockers	Calcium gluconate and/or Calcium chloride	Calcium 500 mEq* [CaCl 13.6 mEq/10 mL x 50; CaGlu 4.65 mEg/10 mL x 100]	Dose varies by agent/context.	Ca chloride 10% recommended for administration by central venous catheter. Ca gluconate can be given through a peripheral vein.
1	2) High dose insulin/glucose	Regular Insulin 3500 Units ***	Bolus 1 U/kg regular insulin + 25-50 g dextrose (adult); Infuse 0.5-1 U/kg/hr	Give in ICU setting: monitor glucose. Response may be delayed 30-60 min. Has also been used in beta blocker toxicity.
	-		insulin and dextrose to maintain euglycemia.	* * * * * * * * * * * * * * * * * * * *
Carbon Monoxide Cesium (radioactive) or	Oxygen Prussian blue (Radiogardase®)	Provision blue 0.5 o per cansula: one hottle /36	 1) 100% Oxygen 2) Hyperbaric Oxygen Adults and Adolescents: 3 g (6 capsules) taken orally tid (daily dose of 9 g). 	Call PC for indications for using hyperbaric oxygen. Treatment with Prussian blue may be needed for at least 30 days. May cause constipation. Is excreted primarily in feces and turns
Thallium (radioactive or non-		capsules) would treat one adult for 2 days ***	Child: 1 g (2 capsules) taken orally tid (daily dose of 3 g).	stools blue. May bind to electrolytes in the GI tract and cause hypokalemia. Monitor serum electrolytes during treatment. Access
radioactive)			** * * * * * * * * * * * * * * * * * * *	to a regional supply may be sufficient for most hospitals.
	1) Atropine		Initial dose, Adult: 1-5 mg IV repeat q 5 min until reversal of bronchospasm	Dosing of atropine in adults should be increased if there is no response, and should be given until cessation of excessive oral and
(Organophosphates; Carbamates; Nerve Agents)		(0.4 mg/mL) x 413; OR 10 mL (0.1 mg/mL) x 165)	and excessive secretions. Child: 0.02 mg/kg IV repeat q 10-15 min pm. Continuous IV atropine: 10-20% of the initial dose required to reverse	pulmonary secretions. Stockpiles of atropine and pratidoxime IV vials and auto-injectors are available in CHEMPACKs in all states. Contact PC or state health department for access information.
Carbaniases, Herre Agents)		1	muscarinic s/sx can be given as an hourly infusion.	venturi v vi sute nami vepatinim vi avesso manadoni
	2) Pralidoxime (2-PAM, Protopam®)	2) 18 g* [10 mL vials 100 mg/mL x 18]		Pralidoxime may be given over 2 min for life-threatening nicotinic effects. Indicated in organophosphate poisoning. Give in addition
			of 8-10 mg/kg/hr (up to 650 mg/hr). Child: initial bolus 25-50 mg/kg over 15-30 min. Maintenance infusion of 10-20 mg/kg/hr (up to 650 mg/hr).	to atropine. Efficacy in carbamate toxicity is controversial. Contraindicated in carbaryl (Sevin®) exposure.
Cyanide	1) Hydroxocobalamin (Cyanokit®)	10 g* (2 kits)	Adult: 5 g; Child: 70 mg/kg IV over 15-30 min. Repeat dose as needed.	Preferred treatment (especially for cyanide poisoning due to smoke inhalation). If possible, draw labs prior to administration as
,	, , , , ,	, , , , , , , , , , , , , , , , , , , ,		hydroxocobalamin may interfere with certain laboratory assays. Can be repeated as clinically necessary. Na thiosulfate can be co-
				administered through a separate IV line. Side effects include transient hypertension, red skin discoloration, and chromaturia.
	2) Sodium Nitrite and Sodium Thiosulfate	600 mg/25 g (2 kits)	Sodium Nitrite: Adult: 10 mL fV at rate of 2.5-5 mL/min; Child: 0.2 mL/kg	Sodium thiosulfate (but not sodium nitrite) can be given as adjunctive treatment to hydroxocobalamin to enhance cyanide clearance.
	(Nithiodote®)		(6 mg/kg) IV at rate of 2.5-5 mL/min. Followed by Sodium Thiosulfate: Adult:	Do not give through same IV line as hydroxocobalamin.
Cools totidessesses and	Systemic alkalinization with Sodium	Na bicarbonate***	50 ml, 25% solution IV; Child: 1 mL/kg 25% solution IV.	Controls all deleterates for demonstrated and an absorb blackeds deletered ORC DC constitution absorbs assessed at
	Bicarbonate	[50 mL vials (1 mEq/mL) x 20]	Na bicarbonate: 1-2 mEq/kg IV bolus followed by maintenance infusion at a rate of 2-3 mL/kg/hr. Goal pH is 7.45-7.55.	Systemic alkalinization for demonstrated sodium channel blockade (widened QRS). PC consultation strongly recommended. Prepare infusion by placing 3 ampules of Na bicarbonate (50 mEg each) in one liter of DSW. Sodium acetate may be used as an
Blockers (e.g.,		,,		alternative if Na bicarbonate is unavailable (infusion only).
Diphenhydramine)				
Digoxin	Digoxin Immune Fab (Digibind®, DIGIFab®)	10-20 vials*	#Vials = (Digoxin Serum Conc (ng/mL) x Wt. (kg)/100. If unknown: Acute OD = 10-20 vials; Chronic Adult OD = 3 to 6 vials; Chronic Child OD = 1 vial.	Monitor ECG and potassium levels. Digoxin assay may not be accurate after administration of Digoxin Immune Fab.
Ethylene Glycol	1) Fomepizole (Antizoli8)	Fomepizole 7 g* [1.5 g vials x 5]	Fomepizole: 15 mg/kg IV LD; 10 mg/kg IV q 12 hr x 4 doses, then 15 mg/kg	Fomepizole is preferred over ethanol. Call PC for use of ethanol and for hemodialysis indications.
	2) Thiamine 3) Pyridoxine	***	thereafter. During dialysis, re-dose q 4 hr. Thiamine 100 mg IV q 6 hr and Pyridoxine 50 mg IV q 6 hr for 24 hours.	Thiamine and pyridoxine for enhanced elimination of metabolic acids.
GI Decontamination	Activated charcoal without cathartic	100 g*	Adult: 25 - 100 g; Child: 1 g/kg.	Use only if patient is allert enough to protect airway and bowel sounds are present. Concern for aspiration if patient is obtunded.
				Contraindicated with caustics. Ineffective with many metals.
Hydrofluoric Acid	Polyethylene glycol (PEG) Calcium gluconate	10 L	Adult or adolescent: 1.5 -2 L/hr; Child: 25 mL/kg/h or 500 mL/hr. Topical: calcium gluconate or crushed calcium carbonate tablets mixed with	Whole bowel irrigation with PEG reserved for GI decontamination following toxic ingestions. Consult PC for guidance. Selection of agent, route and dose varies by exposure history and symptomatology. Calcium chloride should be given through a
	Cacian goconare	Calcium 500 mEq* (CaCl 13.6 mEq/10 ml, x 50; CaGlu 4.65	water-soluble lubricant applied to burn and covered. Call PC for details.	central line, use calcium gluconate if giving peripherally. Calcium chloride should not be given subcutaneously. Hypocalcemia and life-
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lodine (radioactive) (I-131) Iron Isoniazid Metals: Lead, Mercury, Arsenic	Potassium iodide (KI) Deferoxamine (Desferal®) Pyridoxine 1) Succimer (DMSA)	[CaCl 13.6 mEq/10 ml. x 50; CaGlu 4.65 mEq/10 ml. x 100] 130 mg* 6-12 g* [500 mg/5 ml. vials x 12-24] 8 g* (100 mg/ml.) x 80] 3 g**	water-soluble lubricant applied to burn and covered. Call PC for details. For topical treatment failures, give SQ: Inject 0.5 mL/cm? with 10% calcium gluconate (do not use calcium chloride). Adult: 130 milligrams/day orally. Child: 3-18 yrs: 65 mg/day. Infant: 1 mo-3 yrs: 32 mg/day. Neonate: 0-1 mo: 16 mg/day. Start influsion at 5 mg/lag/hr and increase to 15 mg/kg/hr over 15 min. Mild to moderate toxicity, duration 6-12 hr; Severe toxicity, duration 24 hr, then reassess. Mg for mg ingested dose. Empiric dose: Adult: 5 g: Child: 75 mg/kg, IV influsion 0, 5 g/min till setzures stop, then remainder over 4-6 hours. 10 mg/kg (max per dose 500 mg) PO tid x 5 days, then bid x 14 days. 3-5 mg/kg/dose deep IM q 4 hr x 2 days, then q 4-6 hr x 2 days.	central line, use calcium gluconate if giving peripherally. Calcium chloride should not be given subcutaneously. Hypocalcemia and life threatening arrhythmias possible from all routes of exposure. Contact PC for case-specific advice. Start as soon as possible (< 3-4 hr.). Adults 18-40 years with exposure ≥10 centigray (cGy). Over 40 years of age need KI only with large internal dose (±500 cGy). Children, pregnant and lactating women should be treated at lower exposure doses. Indications for treatment: asymptomatic patient with peak serum iron ±500 mcg/std., symptomatic patient symptomatic patient iron iron iron iron iron iron iron iron
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lodine (radioactive) (I-131) Iron Isoniazid Metals: Lead, Mercury, Arsenic	Potassium iodide (KI) Deferoxamine (Desferal®) Pyridoxine 1) Succimer (DMSA) 2) BAL (dimercaprol)	[CaCl 13.6 mEq*10 ml. x 50; CaGlu 4.65 mEq*10 ml. x 100] 130 mg* 6-12 g* [500 mg/5 ml. vials x 12-24] 8 g* (100 mg/ml.) x 80] 3 g** 3 g** [3 ml. ampules (100 mg/ml.) x 10]	water-soluble lubricant applied to burn and covered. Call PC for details. For topical treatment failures, give SQ: Inject 0.5 mL/cm? with 10% calcium gluconate (do not use calcium chloride). Adult: 130 milligrams/day orally. Child: 3-18 yrs: 65 mg/day; Infant: 1 mo-3 yrs: 32 mg/day. Neonate: 0-1 mo: 16 mg/day. Start influsion at 5 mg/lag/ Neonate: 0-1 mo: 16 mg/day. Start influsion at 5 mg/lag/ Neonate: 0-1 mo: 16 mg/day. Start influsion at 5 mg/lag/ Neonate: 0-1 mo: 16 mg/day. Start influsion 0-5 grinis dose. Empiric dose: Adult: 5 g. Child: 75 mg/lag, IV Influsion 0-5 grinis till setures stop, then remainder over 4-6 hours. 10 mg/lag (max per dose 500 mg) PO tid x 5 days, then bid x 14 days. 3-5 mg/kg/dose deep IM q 4 hr x 2 days, then q 4-6 hr x 2 days. 1500 mg/m²/day IV (up to 2-3 g) over 8-12 hr x 5 days (started 4 hr after BAL). Formepizole 15 mg/kg IV LD; 10 mg/kg IV q 12 hr x 4 doses, then 15 mg/kg IV	central line, use calcium gluconate if giving peripherally. Calcium chloride should not be given subcutaneously. Hypocalcemia and life threatening arrhythmias possible from all routes of exposure. Contact PC for case-specific advice. Start as soon as possible (< 3-4 hr.). Adults 18-40 years with exposure ≥10 centigray (cGy). Over 40 years of age need KI only with large internal dose (≥500 cGy). Children, preparat and lactating women should be treated at lower exposure doses. Indications for treatment: asymptomatic patient with peak serum iron ≥500 mcg/st., symptomatic patient with peak serum iron ≥500 mcg/st., symptomatic patient with peak serum iron ≥500 mcg/st., symptomatic patient with peak serum iron ≥350 mcg/st., symptomatic patient sympto
lodine (radioactive) (I-131) Iron Isoniazid Metals: Lead, Mercury, Arsenic	Potassium iodide (KI) Deferoxamine (Desferal®) Pyridoxine 1) Succimer (DMSA) 2) BAL (dimercaprol) 3) Calcium disodium EDTA	[CaCl 13.6 mEq*10 mL x 50; CaGlu 4.65 mEq*10 mL x 100] 130 mg* 6-12 g* [500 mg/5 mL vials x 12-24] 8 g* (100 mg/mL) x 80] 3 g** 3 g** [3 mL ampules (100 mg/mL) x 10] 15 g** Fornepizole 7 g* [1.5 g vials x 5] Folic acid 300 mg***	water-soluble lubricant applied to burn and covered. Call PC for details. For topical treatment failures, give SiQ: Inject 0.5 mL/cm² with 10% calcium gluconate (do not use calcium chloride). Adult: 130 milligrams/day orally: Child: 3-18 yrs: 65 mg/day; Infant: 1 mo-3 yrs: 32 mg/day; Neonate: 0-1 mo: 16 mg/day. Start infusion at 5 mg/kg/hr and increase to 15 mg/kg/hr over 15 min. Mild to moderate toxicity, duration 6-12 hr; Severe toxicity, duration 6-12 hr; Sever	central line, use calcium gluconate if giving peripherally. Calcium chloride should not be given subcutaneously. Hypocalcemia and life threatening arrhythmias possible from all routes of exposure. Contact PC for case-specific advice. Start as soon as possible (< 3-4 hr). Adults 18-40 years with exposure ≥10 centigray (cGy). Over 40 years of age need KI only with large internal dose (±500 cGy). Children, pregnant and lactating women should be treated at lower exposure doses. Indications for treatment: asymptomatic patient with peak serum iron ≥500 mcg/std., symptomatic patient with peak serum iron ≥500 mcg/std., symptomatic patient with peak serum iron ≥350 mcg/std., symptomatic patient iron peak sym
lodine (radioactive) (I-131) Iron Isoniazid Metals: Lead, Mercury, Arsenic	Potassium iodide (KI) Deferoxamine (Desferal®) Pyridoxine 1) Succimer (DMSA) 2) BAL (dimercaprol) 3) Calcium disodium EDTA 1) Fomepizole (Antizol®) 2) Folic acid or folinic acid (leucovorin)	[CaCl 13.6 mEq*10 ml, x 50; CaGlu 4.65 mEq*10 ml, x 100] 130 mg* 6-12 g* [500 mg/5 ml, vials x 12-24] 8 g* (100 mg/mL) x 80] 3 g** 3 g** 3 g** 3 ml, ampules (100 mg/mL) x 10] 15 g** Fomepizole 7 g* [1.5 g vials x 5] Folic acid 300 mg** [10 ml, vials (5 mg/mL) x 6]	water-soluble lubricant applied to burn and covered. Call PC for details. Por topical treatment failures, give SC2: Inject 0.5 mL/cm² with 10% calcium gluconate (do not use calcium chloride). Adult: 130 milligrams/day orally. Child: 3-18 yrs: 65 mg/day. Infant: 1 mo-3 yrs: 32 mg/day. Neonate: 0.7 mo: 16 mg/day. Start infinsion at 5 mg/kg/hr and increase to 15 mg/kg/hr over 15 min. Mild to moderate toxicity, duration 6-12 hr; Severe toxicity, duration 24 hr; then reassess. Mg for mg ingested dose. Empiric dose: Adult: 5-g: Child: 75 mg/kg, IV infusion 0.5 g/min till setzures stop, then remainder over 4-6 hours. 10 mg/kg (max per dose 500 mg) PO tid x 5 days, then bid x 14 days. 3-5 mg/kg/dose deep IM q 4 hr x 2 days, then q 4-6 hr x 2 days. 1500 mg/m²/day IV (up to 2-3 g) over 8-12 hr x 5 days (started 4 hr after BAL). Q 12 hr thereafter. During dalysis, re-dose q 4 hours. 1 mg/kg up to 50 mg in an adult q 4 hr for 24 hours.	central line, use calcium gluconate if giving peripherally. Calcium chloride should not be given subcutaneously. Hypocalcemia and life threatening arrhythmias possible from all routes of exposure. Contact PC for case-specific advice. Start as soon as possible (< 3-4 hr). Adults 18-40 years with exposure ≥10 centigraly (cGy). Over 40 years of age need KI only with large internal dose (≥500 cGy). Children, preparat and lactating women should be treated at lower exposure doses. Indications for treatment: asymptomatic patient with peak serum iron ≥500 mcg/stl., symptomatic patient with peak serum iron ≥350 mcg/stl., symptomatic patient symptomatic patients. May only be given IM. Contraindicated in patients with peanut allergy. BAL is currently unavailable. Calcium disodum EDTA must be started after BAL to decrease CNS lead penetration. Access to a regional supply may be sufficient for most hospitalis. Forepizole is preferred over ethanol. Call PC for use of ethanol metabolic products. Folinic acid (leucovorin) should be used if there is any acidosis. Ditute in 100 mt., DSW and give IV over 30-60 minutes.
lodine (radioactive) (I-131) Iron Isoniazid Metals: Lead, Mercury, Arsenic Methanol Methemoglobin-Producing	Potassium iodide (KI) Deferoxamine (Desferal®) Pyridoxine 1) Succimer (DMSA) 2) BAL (dimercaprol) 3) Calcium disodium EDTA 1) Fomepizole (Antizol®) 2) Folic acid or folinic acid (leucovorin)	[CaCl 13.6 mEq*10 mL x 50; CaGlu 4.65 mEq*10 mL x 100] 130 mg* 6-12 g* [500 mg/5 mL vials x 12-24] 8 g* (100 mg/mL) x 80] 3 g** 3 g** [3 mL ampules (100 mg/mL) x 10] 15 g** Fornepizole 7 g* [1.5 g vials x 5] Folic acid 300 mg***	water-soluble lubricant applied to burn and covered. Call PC for details. For topical treatment failures, give SiQ: Inject 0.5 mL/cm² with 10% calcium gluconate (do not use calcium chloride). Adult: 130 milligrams/day orally: Child: 3-18 yrs: 65 mg/day; Infant: 1 mo-3 yrs: 32 mg/day; Neonate: 0-1 mo: 16 mg/day. Start infasion at 5 mg/hg/hr and increase to 15 mg/kg/hr over 15 min. Mild to moderate toxicity, duration 6-12 hr; Severe toxicity, duration 24 hr, then reassess. Mg for mg ingested dose. Empiric dose: Adult: 5 g; Child: 75 mg/kg, IV infusion 0.5 g/min till seltures stop, then remainder over 4-6 hours. 10 mg/kg (max per dose 500 mg) PO tid x 5 days, then bid x 14 days. 3-5 mg/kg/dose deep IM q 4 hr x 2 days, then q 4-6 hr x 2 days. 1500 mg/m²/day IV (up to 2-3 g) over 8-12 hr x 5 days (started 4 hr after BAL). Fomepizole 15 mg/kg IV LD; 10 mg/kg IV q 12 hr x 4 doses, then 15 mg/kg IV q 12 hr thereafter. During dialysis, re-dose q 4 hours. 1 mg/kg up to 50 mg in an adult q 4 hr for 24 hours. 1 mg/kg up to 50 mg in an adult q 4 hr for 24 hours.	central line, use calcium gluconate if giving peripherally. Calcium chloride should not be given subcutaneously. Hypocalcemia and life threatening arrhythmias possible from all routes of exposure. Contact PC for case-specific advice. Start as soon as possible (< 3-4 hr). Adults 18-40 years with exposure ≥10 centigray (cGy). Over 40 years of age need KI only with large internal dose (≥500 cGy). Children, pregnant and lactating women should be treated at lower exposure doses. Indications for treatment: asymptomatic patient with peak serum iron ≥500 mcg/st., symptomatic patient with peak serum iron ≥500 mcg/st., symptomatic patient with peak serum iron ≥350 mcg/st., symptomatic patient iron patients with Gyromitra (false morel) mushroom and hydrazine (e.g., jet fivel) toxicity. BAL given only if encephalopathy and/or unable to take PO. Access to a regional supply may be sufficient patients. May only be given IM. Contraindicated in patients with peanut allergy. BAL is currently unavailable. Calcium disodium EDTA must be started after BAL to decrease CNS lead penetration. Access to a regional supply may be sufficient for most hospitals. Fonepizole is preferred over ethanol. Call PC for use of ethanol and for hemodialysis indications. Folic acid and folinic acid may hasten elimination of methanol metabolic products. Folinic acid (leucovorin) should be used if there is any acidosis. Diute in 100 ml. DSW and give IV over 30-60 minutes.
lodine (radioactive) (I-131) Iron Isoniazid Metals: Lead, Mercury, Arsenic Methanol Methemoglobin-Producing Agents	Potassium iodide (KI) Deferoxamine (Desferal®) Pyridoxine 1) Succimer (DMSA) 2) BAL (dimercaprol) 3) Calcium disodium EDTA 1) Fomepizole (Antizol®) 2) Folic acid or folinic acid (leucovorin)	[CaCl 13.6 mEq*10 ml, x 50; CaGlu 4.65 mEq*10 ml, x 100] 130 mg* 6-12 g* [500 mg/5 ml, vials x 12-24] 8 g* (100 mg/mL) x 80] 3 g** 3 g** 3 g** 3 ml, ampules (100 mg/mL) x 10] 15 g** Fomepizole 7 g* [1.5 g vials x 5] Folic acid 300 mg** [10 ml, vials (5 mg/mL) x 6]	water-soluble lubricant applied to burn and covered. Call PC for details. Por topical treatment failures, give SC2: Inject 0.5 mL/cm² with 10% calcium gluconate (do not use calcium chloride). Adult: 130 milligrams/day orally. Child: 3-18 yrs: 65 mg/day. Infant: 1 mo-3 yrs: 32 mg/day. Neonate: 0.7 mo: 16 mg/day. Start infinsion at 5 mg/kg/hr and increase to 15 mg/kg/hr over 15 min. Mild to moderate toxicity, duration 6-12 hr; Severe toxicity, duration 24 hr; then reassess. Mg for mg ingested dose. Empiric dose: Adult: 5-g: Child: 75 mg/kg, IV infusion 0.5 g/min till setzures stop, then remainder over 4-6 hours. 10 mg/kg (max per dose 500 mg) PO tid x 5 days, then bid x 14 days. 3-5 mg/kg/dose deep IM q 4 hr x 2 days, then q 4-6 hr x 2 days. 1500 mg/m²/day IV (up to 2-3 g) over 8-12 hr x 5 days (started 4 hr after BAL). Q 12 hr thereafter. During dalysis, re-dose q 4 hours. 1 mg/kg up to 50 mg in an adult q 4 hr for 24 hours.	central line, use calcium gluconate if giving peripherally. Calcium chloride should not be given subcutaneously. Hypocalcemia and life threatening arrhythmias possible from all routes of exposure. Contact PC for case-specific advice. Start as soon as possible (< 3-4 hr.). Adults 18-40 years with exposure ≥10 centigray (cGy). Over 40 years of age need KI only with large internal dose (≥500 cGy). Children, pregnant and lactating women should be treated at lower exposure doses. Indications for treatment: asymptomatic patient with peak serum iron ≥500 mcg/st., symptomatic patient with peak serum iron ≥350 consider stocking ≥0 g in tuberoulosis-endemic areas. Pyridoxine also used with Gyromitra (false morel) mushroom and hydrazine (e.g., jet fixel) toxicity. BAL given only if encephalopathy andior unable to take PO. Access to a regional supply may be sufficient for most hospitals. BAL given only if encephalopathy andior unable to take PO. Access to a toxic PO Succimer. May indice hemolysis in G8PD deficient patients. May only be given IM. Contraindicated in patients with peanut allergy. BAL is currently unavailable. Calcium disodium BDTA must be started after BAL to decrease CNS lead penetration. Access to a regional supply may be sufficient for most hospitals. Fomepizole is preferred over ethanol. Call PC for use of ethanol and for hemodalysis indications. Folic acid and folinic acid may hasten elimination of methanol metabolic products. Folinic acid (leucovorin) should be used if there is any acidosis. Diute in 100 ml. DSW and give IV over 30.60 minutes. Live methylene blue for symptomatic.
lodine (radioactive) (I-131) Iron Isoniazid Metals: Lead, Mercury, Arsenic Methanol Methanol	Potassium iodide (KI) Deferoxamine (Desferal®) Pyridoxine 1) Succimer (DMSA) 2) BAL (dimercaprol) 3) Calcium disodium EDTA 1) Fomepizole (Antizol®) 2) Folic acid or folinic acid (leucovorin)	[CaCl 13.6 mEq*10 ml, x 50; CaGlu 4.65 mEq*10 ml, x 100] 130 mg* 6-12 g* [500 mg/5 ml, vials x 12-24] 8 g* (100 mg/mL) x 80] 3 g** 3 g** 3 g** 3 ml, ampules (100 mg/mL) x 10] 15 g** Fomepizole 7 g* [1.5 g vials x 5] Folic acid 300 mg** [10 ml, vials (5 mg/mL) x 6]	water-soluble lubricant applied to burn and covered. Call PC for details. For topical treatment failures, give SQ: Inject 0.5 mL/cm² with 10% calcium gluconate (do not use calcium chloride). Adult: 130 milligrams/day orally. Child: 3-18 yrs: 65 mg/day. Infant: 1 mo-3 yrs: 32 mg/day. Neonate: 0-1 mo: 16 mg/day. Start influsion at 5 mg/lag/hr and increase to 15 mg/kg/hr over 15 min. Mild to moderate toxicity, duration 6-12 hr, Severe toxicity, duration 24 hr, then reassess. Mg for mg ingested dose. Empiric dose: Adult: 5 g. Child: 75 mg/kg, IV influsion 0.5 g/min till setures stop, then remainder over 4-6 hours. 10 mg/kg (max per dose 500 mg) PO tid x 5 days, then bid x 14 days. 3-5 mg/kg/dose deep IM q 4 hr x 2 days, then q 4-6 hr x 2 days. 1500 mg/m²/day IV (up to 2-3 g) over 8-12 hr x 5 days (started 4 hr after BAL). Formepicale 15 mg/kg IV LD: 10 mg/kg IV q 12 hr x 4 doses, then 15 mg/kg IV q 12 hr thereafter. During dialysis, re-dose q 4 hours. 1 mg/kg IV over 5-30 min. If methemoglobin level remains above 30% or chinical symptoms persist, give a repeat dose of up to 1 mg/kg one hour after	central line, use calcium gluconate if giving peripherally. Calcium chloride should not be given subcutaneously. Hypocalcemia and life threatening arrhythmias possible from all routes of exposure. Contact PC for case-specific advice. Start as soon as possible (< 3-4 hr). Adults 18-40 years with exposure ≥10 centigray (cGy). Over 40 years of age need KI only with large internal dose (≥500 cGy). Children, pregnant and lactating women should be treated at lower exposure doses. Indications for treatment: asymptomatic patient with peak serum iron ≥500 mcg/st., symptomatic patient with peak serum iron ≥500 mcg/st., symptomatic patient with peak serum iron ≥350 mcg/st., symptomatic patient iron patients with Gyromitra (false morel) mushroom and hydrazine (e.g., jet fivel) toxicity. BAL given only if encephalopathy and/or unable to take PO. Access to a regional supply may be sufficient patients. May only be given IM. Contraindicated in patients with peanut allergy. BAL is currently unavailable. Calcium disodium EDTA must be started after BAL to decrease CNS lead penetration. Access to a regional supply may be sufficient for most hospitals. Fonepizole is preferred over ethanol. Call PC for use of ethanol and for hemodialysis indications. Folic acid and folinic acid may hasten elimination of methanol metabolic products. Folinic acid (leucovorin) should be used if there is any acidosis. Diute in 100 ml. DSW and give IV over 30-60 minutes.
lodine (radioactive) (I-131) Iron Isoniazid Metals: Lead, Mercury, Arsenic Methanol Methemoglobin-Producing Agents Methotrexate	Potassium iodide (KI) Deferoxamine (Desferal®) Pyridoxine 1) Succimer (DMSA) 2) BAL (dimercaprol) 3) Calcium disodium EDTA 1) Fomeplacie (Antizot®) 2) Folic acid or folinic acid (leucovorin) Methylene Blue Folinic acid (leucovorin)	[CaCl 13.6 mEq*10 ml. x 50; CaGlu 4.65 mEq*10 ml. x 100] 130 mg* 6-12 g* [500 mg/5 ml. vials x 12-24] 8 g* (100 mg/ml.) x 60] 3 g** 3 g** [3 ml. ampules (100 mg/ml.) x 10] 15 g** Fomepisole 7 g* [1.5 g vials x 5] Folic soid 300 mg** [10 ml. ampules (10 mg/ml.) x 6] 800 mg* [10 ml. ampules (10 mg/ml.) x 6]	water-soluble lubricant applied to burn and covered. Call PC for details. For topical treatment failures, give SiQ: Inject 0.5 mL/cm² with 10% calcium gluconian (60 not use calcium chloride). Adult: 130 milligrams/day orathy: Child: 3-18 yrs: 65 mg/day; Infent: 1 mo-3 yrs: 32 mg/day; Neonate: 0-1 mo: 16 mg/day. Start infesion at 5 mg/kg/hr and increase to 15 mg/kg/hr over 15 min. Mild to moderate toxicity, duration 6-12 hr; Severe toxicity, duration 24 hr; then reassess. Mg for mg ingested dose. Empiric dose: Adult: 5 g. Child: 75 mg/kg, IV infusion 0.5 g/min till selbures stop, then remainder over 4-6 hours. 10 mg/kg (max per dose 500 mg) PQ tid x 5 days, then bid x 14 days. 3-5 mg/kg/dose deep IM q 4 hr x 2 days, then q 4-6 hr x 2 days. 1500 mg/m²/day IV (up to 2-3 g) over 8-12 hr x 4 doses, then 15 mg/kg (V q 12 hr x 4 doses, then 15 mg/kg IV q 12 hr x 4 doses, then 15 mg/kg IV g 12 hr x 6 mg/kg IV q 12 hr x 6 mg/kg IV g 12 hr x 6	central line, use calcium gluconate if giving peripherally. Calcium chloride should not be given subcutaneously. Hypocalcemia and life threatening arrhythmias possible from all routes of exposure. Contact PC for case-specific advice. Start as soon as possible (< 3-4 hr.). Adults 18-40 years with exposure ≥10 centigray (cGy). Over 40 years of age need KI only with large internal dose (≥500 cGy). Children, pregnant and lactating women should be treated at lower exposure doses. Indications for treatment: asymptomatic patient with peak serum iron ≥500 mcg/st., symptomatic patients with peak serum iron ≥500 mcg/st., symptomatic patients. As a symptomatic patient is symptomatic patients. Visible cyanosis occurs at methemoglobin levels of 10-15% but may not require treatment if patient is asymptomatic. Foliate reductase inhibitor requires folinic acid instead of foliate. Most effective if given within 1 hr; may be ineffective beyond 4 hr.
lodine (radioactive) (I-131) Iron Isoniazid Metals: Lead, Mercury, Arsenic Methanol Methemoglobin-Producing Agents Methodrexate Opioids	Potassium iodide (KI) Deferoxamine (Desferal®) Pyridoxine 1) Succimer (DMSA) 2) BAL (dimercaprol) 3) Calcium disodium EDTA 1) Fomepisole (Antizot®) 2) Folic acid or folinic acid (leucovorin) Methylene Blue Folinic acid (leucovorin) Naloxone (Narcan®)	[CaCl 13.6 mEq*10 ml. x 50; CaGlu 4.65 mEq*10 ml. x 100] 130 mg* 6-12 g* [500 mg/5 ml. vials x 12-24] 8 g* (100 mg/ml.) x 60] 3 g** 3 g** [3 ml. ampules (100 mg/ml.) x 10] 15 g** Fomepiacle 7 g* [1.5 g vials x 5] Foile acid 300 mg** [10 ml. vials (5 mg/ml.) x 6] 600 mg* [10 ml. ampules (10 mg/ml.) x 6] 20 mg* [10 ml. ampules (0.4 mg/ml.) x 5]	water-soluble lubricant applied to burn and covered. Call PC for details. For topical treatment failures, give SiQ: Inject 0.5 mL/cm² with 10% calcium gluconate (66 not use calcium chloride). Adult: 130 milligrams/day orally: Child: 3-18 yrs: 65 mg/day; Infent: 1 mo-3 yrs: 32 mg/day; Neonate: 0-1 mo: 16 mg/day. Start infesion at 5 mg/kg/hr and increase to 15 mg/kg/hr over 15 min. Mild to moderate toxicity, duration 6-12 hr; Severe toxicity, duration 24 hr; then reassess. Mg for mg ingested dose. Empiric dose: Adult: 5 g. Child: 75 mg/kg, IV infusion 0.5 g/min till selbures stop, then remainder over 4-6 hours. 10 mg/kg (max per dose 500 mg) PO tid x 5 days, then bid x 14 days. 3-5 mg/kg/dose deep IM q 4 hr x 2 days, then q 4-6 hr x 2 days. 1500 mg/m²/day IV (up to 2-3 g) over 8-12 hr x 4 doses, then 15 mg/kg IV q 12 hr x 4 doses, then 15 mg/kg IV q 12 hr x 4 doses, then 15 mg/kg IV q 12 hr x 4 doses, then 15 mg/kg IV q 12 hr x 4 doses, then 15 mg/kg IV q 12 hr x 4 doses, then 15 mg/kg IV q 12 hr x 4 doses, then 15 mg/kg IV g 12 hr x 4 doses, then 15 mg/kg IV g 12 hr x 4 doses, then 15 mg/kg IV g 12 hr x 4 doses, then 15 mg/kg IV g 12 hr x 4 doses, then 15 mg/kg IV q 12 hr x 4 doses, then 15 mg/kg IV g 12 hr x 4 doses, then 15 mg	central line, use calcium gluconate if giving peripherally. Calcium chloride should not be given subcutaneously. Hypocalcemia and life threatening arrhythmias possible from all routes of exposure. Contact PC for case-specific advice. Start as soon as possible (< 3-4 hr). Adults 18-40 years with exposure ≥10 centigray (cGy). Over 40 years of age need KI only with large internal dose (≥500 cGy). Children, pregnant and lactating women should be treated at lower exposure doses. Indications for treatment: asymptomatic patient with peak serum iron ≥500 mcg/sl., symptomatic patient with peak serum iron ≥500 mcg/sl., symptomatic patient with peak serum iron ≥500 mcg/sl., symptomatic patient with peak serum iron ≥500 mcg/sl. or severe symptoms following iron ingestion. Benefit of deferovamine beyond 24-48 hours unlikely and increased risk of pulmonary toxicity. Consider stocking 20 g in tuberculosis-endemic areas. Pyridoxine also used with Gyromitra (false morel) mushroom and hydrazline (e.g., jet fixel) toxicity. BAL given for encephalopathy andior unable to take PO. Access to a regional supply may be sufficient for most hospitals. BAL given only if encephalopathy andior unable to take PO. Access to a toxic PO Succimer. May induce hemolysis in G8PD deficient patients. May only be given IM. Contraindicated in patients with peanut allergy, BAL is currently unavailable. Calcium disodium EDTA must be started after BAL to decrease CNS lead penetration. Access to a regional supply may be sufficient for most hospitals. Formepixole is preferred over ethanol. Call PC for use of ethanol and for hemodalysis indications. Folic acid and folicie acid may hasten elimination of mentanolic products. Folicic acid (leucovorin) should be used if there is any acidosis. Diute in 100 ml. DSW and give IV over 30-60 minutes. Use methylene blue for symptomatic patients. Visible cyanosis occurs at methemoglicibin levels of 10-15% but may not require treatment if patient is asymptomatic. Foliate reductase inhibitor require folicic acid i
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lodine (radioactive) (I-131) Iron Isoniazid Metals: Lead, Mercury, Arsenic Methanol Methemoglobin-Producing Agents Methotrexate Opioids Salicylates Snakebites: Rattlesmake, Copperhead, Cottonmouth	Potassium iodide (KI) Deferoxamine (Desferal®) Pyridoxine 1) Succimer (DMSA) 2) BAL (dimercaprof) 3) Calcium disodium EDTA 1) Fomepizole (Antizol®) 2) Folic acid or folinic acid (leucovorin) Methylene Blue Folinic acid (leucovorin) Naloxone (Narcan®) Urinary alkalinization with Na bicarbonate 1) Crotaldae Polyvalent Immune Fab Antivenom (CroFab®)	CaCl 13.6 mEq*10 ml. x 50; CaGlu 4.65 mEq*10 ml. x 100] 130 mg* 6-12 g* [500 mg/5 ml. vials x 12-24] 8 g* (100 mg/ml.) x 80] 3 g** [3 ml. ampules (100 mg/ml.) x 10] 15 g** Fotic acid 300 mg** [10 ml. ampules (10 mg/ml.) x 6] 600 mg* [10 ml. ampules (10 mg/ml.) x 6] 10 mg* [10 ml. ampules (10 mg/ml.) x 6] 10 mg* [10 ml. ampules (10 mg/ml.) x 5] 12 mg* [10 ml. ampules (0.4 mg/ml.) x 5] 12 mg* [10 ml. ampules (0.4 mg/ml.) x 5] 12 mg* [10 ml. ampules (0.4 mg/ml.) x 5] 12 mg* [10 ml. ampules (0.4 mg/ml.) x 20] 12 ml. vials (1 mEg/ml.) x 20] 12 ml. vials (1 mEg/ml.) x 20]	water-soluble lubricant applied to burn and covered. Call PC for details. For topical treatment failures, give SiQ: Inject 0.5 mL/cm² with 10% calcium gluconiare (do not use calcium chloride). Adult: 130 milligrams/day orally: Child: 3-18 yrs: 65 mg/day; Infant: 1 mo-3 yrs: 32 mg/day; Neonate: 0-1 mo: 16 mg/day. Start infasion at 5 mg/kg/hr and increase to 15 mg/kg/hr over 15 min. Mild to moderate toxicity, duration 6-12 hr; 5 evere toxicity, duration 2-4 hr; ten reassess. Mg for mg ingested dose. Empiric dose: Adult: 5 g: Child: 75 mg/kg, IV infusion 0.5 g/min till seltures stop, then remainder over 4-6 hours. 10 mg/kg/dose deep IM q 4 hr x 2 days, then q 4-6 hr x 2 days. 3-5 mg/kg/dose deep IM q 4 hr x 2 days, then q 4-6 hr x 2 days. 1500 mg/m²/day IV (up to 2-3 g) over 8-12 hr x 5 days (started 4 hr after BAL). Fomepizole 15 mg/kg IV LD; 10 mg/kg IV q 12 hr x 4 doses, then 15 mg/kg IV q 12 hr bereafter. Ouring dialysis, re-dose q 4 hours. 1 mg/kg IV over 5-30 min. If methemoglobin level remains above 30% or clinical symptoms persist, give a repeat dose of up to 1 mg/kg goe hour after first dose. Mg for mg ingested dose. Empiric dose for adult is 100 mg/m² q 6 hr IV. 0.4-2.0 mg IV, titrated to effect. An IV infusion may be used once reversal achieved. Na locarbonate: 1-2 mEq/kg IV bolus followed by maintenance infusion at a rate of 2-3 mL/kg/hr. Goal is urine pH of 8 and serum pH of 7.50-7.55. 4-6 vials until milat control, then 2 vials q 6 hr x 3 doses. Vials are reconstituted with 18 mL of 0.9% saline then further diluted to 250 mL.	central line, use calcium gluconate if giving peripherally. Calcium chloride should not be given subcutaneously. Hypocalcemia and life threatening arrhythmias possible from all routes of exposure. Contact PC for case-specific advice, and the provided of the provided provided in the provided
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- A The minimum stocking amount needed to treat at least one 100 kg patient for 24 hours. Higher levels of stocking should be considered and arrangements in place to rapidly obtain additional quantities.
- Stocking is recommended for all acute care hospitals.
 ** No consensus of expert panel regarding stocking requirements.
- *** Stocking is usually based on other indications/use Ref. Dart, et al. Ann Emerg Med 2018; Vol 71, No 3.



