



ASH Draft Recommendations for Treatment of Iron Deficiency and Iron Deficiency Anemia

Introduction

American Society of Hematology (ASH) guidelines are based on a systematic review of available evidence. Through a structured process, a guideline panel makes judgements about the evidence and forms recommendations.

The public comment period occurs after recommendations are formed but before a manuscript report of the guidelines has been finalized and before ASH organizational approval of the guidelines. Comments collected during the open comment period are provided to the guideline panel for review prior to finalizing the guidelines.

These draft recommendations are not final and therefore are not intended for use or citation.

To submit comments on the draft recommendations, **please email guidelines@hematology.org**. Only comments submitted via email will be reviewed by the guideline panel.

The public comment period for these draft recommendations is **October 5 - November 5, 2026**.

Good Practice Statements

All Patient Populations

Good Practice Statement 1: In all patients with iron deficiency, evaluate risk factors and address the underlying cause in addition to providing iron therapy.

Good Practice Statement 2: In all patients treated with iron, reassess the hemoglobin and serum ferritin after treatment to ensure repletion of iron stores.

The optimal timing of reassessment varies based on the degree and etiology of iron deficiency and the method of repletion. Change the iron treatment plan if the response is inadequate.

Good Practice Statement 3: Administer intravenous (IV) iron in settings equipped for appropriate monitoring and staff trained to recognize and manage IV iron infusion reactions.

Good Practice Statement 4: Patients receiving ferric carboxymaltose should have routine monitoring of serum phosphate levels at baseline and 2-6 weeks post-infusion.

- Ferric carboxymaltose should be avoided in patients at risk for osteomalacia or have low serum phosphate levels and discontinued in those who have experienced prolonged or symptomatic hypophosphatemia.
- For patients in whom ongoing IV iron treatment (beyond a single treatment course) is anticipated, non-FCM formulations should be administered due to the boxed warning of hypophosphatemia for FCM.

Recommendations

Iron deficiency without anemia

Question: In patients with iron deficiency without anemia, what is the effect of iron therapy vs no treatment on patient-important outcomes and progression to anemia?

Recommendation 1: The American Society of Hematology Guideline Panel *suggests* iron treatment rather than no treatment for non-pregnant individuals with iron deficiency without anemia who have symptoms or risk factors for developing anemia (conditional recommendation, low certainty of evidence ⊕⊕○○).

Remarks:

- Individuals who are not treated should have ongoing follow-up to reassess for the development of symptoms and/or progression to anemia.
- The choice between IV vs oral treatment should be based on the severity of symptoms, risk factors for developing anemia, whether the patient has a condition that impairs oral iron absorption, how quickly repletion is needed, the side effect profile of each treatment, tolerability of past treatments if provided, out-of-pocket expenses to the patient, and patient preference.

- For pregnant individuals with iron deficiency without anemia, see Recommendation 6.

Good Practice Statement: For adults receiving oral iron therapy, select an iron preparation at a dose of 40 to 65 mg of elemental iron and administer once daily or every other day.

➤ Evidence Profile and Evidence to Decision Framework

Pediatric patients (<18 years of age)

Recommendation 2: The American Society of Hematology Guideline Panel *suggests either* oral iron *or* IV iron for the treatment of iron deficiency anemia in children (conditional recommendation, very low certainty evidence ⊕○○○).

Remarks:

- For children in whom either treatment is reasonable, shared decision-making should consider the expected speed of response, route of administration, treatment duration, need for IV access and infusion visits, potential adverse effects, available IV iron formulations, out-of-pocket expenses to the patient/caregiver, and patient and caregiver preferences.
- Oral iron therapy may be preferred due to the ability to administer at home, lower initial out-of-pocket expenses and resources required, as well as the avoidance of IV access.
- IV iron is preferred in children with severe anemia, upcoming surgery, or other conditions requiring rapid improvement in hemoglobin concentration.
- IV iron is preferred when oral iron cannot be taken or adequately absorbed, such as in children with significant oral aversion, intestinal failure conditions (i.e. short bowel syndrome), inflammation, or other conditions that impair enteral iron absorption as well as for children who do not improve with oral iron due to poor palatability, gastrointestinal intolerance, non-adherence, or have an inadequate erythropoietic response.

➤ Evidence to Decision Framework

Question: Should alternate day iron vs. once daily iron be used for children with confirmed iron deficiency anemia?

Recommendation 3: The American Society of Hematology Guideline Panel *suggests* oral iron administration *either* once daily *or* every other day for the treatment of iron deficiency anemia in children. (conditional recommendation, very low certainty evidence ⊕○○○).

Remarks:

- The choice regarding the dosing schedule and frequency of iron therapy should consider the severity of anemia, anticipated adherence, gastrointestinal adverse effects, and patient and/or caregiver preference through shared decision-making.
- Daily therapy may be preferred when a more rapid erythropoietic response is desired (i.e. in moderate to severe anemia) or when a consistent routine is likely to improve adherence.
- Every other day dosing may be preferred for pediatric patients with mild anemia or iron deficiency without anemia, those who experience gastrointestinal intolerance with daily therapy, or for whom a less frequent schedule is more acceptable.
- For children who cannot tolerate oral iron therapy, cannot absorb oral iron, or in whom there is active inflammation, see Recommendation 2 re: oral versus IV iron therapy.

Good Practice Statement: For young children receiving oral iron therapy, an oral iron salt (ferrous sulfate) at a dose of 3 mg/kg/dose elemental iron is appropriate. For adolescents, standard adult oral iron dosing is appropriate.

➤ [Evidence Profile and Evidence to Decision Framework](#)

Menstruating individuals

Question: Should IV iron vs. Oral iron be used for menstruating individuals with iron deficiency with or without anemia?

Recommendation 4: The American Society of Hematology Guideline Panel *suggests* IV iron rather than oral iron for the treatment of iron deficiency with or without anemia in

menstruating individuals (conditional recommendation, low certainty of evidence ⊕⊕○○).

Remark: Individuals with heavy menstrual bleeding should undergo gynecologic investigation and management of menstrual blood loss. If not regulated, improvement in hemoglobin concentration and iron stores will be limited.

➤ Evidence Profile and Evidence to Decision Framework

Pregnant individuals

Question: Should IV iron vs. oral iron be used for pregnant individuals with iron deficiency anemia?

Recommendation 5: The American Society of Hematology Guideline Panel *suggests* IV iron rather than oral iron for the treatment of iron deficiency anemia in pregnant individuals in the 2nd and 3rd trimesters (conditional recommendation, moderate certainty of evidence ⊕⊕⊕○).

Remarks:

- IV iron should be given *as soon as possible* in the 2nd or 3rd trimester (ideally more than 4 weeks from expected delivery date) to maximize opportunity for the intervention to meaningfully improve hemoglobin concentration.
- Patients should receive a sufficient dose of IV iron to address the iron deficit and ongoing iron requirements of pregnancy.
- IV iron is not approved for administration before 13 weeks of gestational age. Pregnant individuals with iron deficiency anemia in the 1st trimester should receive oral iron as a bridge towards IV iron administered in the 2nd trimester.

➤ Evidence Profile and Evidence to Decision Framework

Question: Should IV Iron vs. Oral Iron be used for pregnant individuals with iron deficiency without anemia?

Recommendation 6: The American Society of Hematology Guideline Panel *suggests* IV iron rather than oral iron for the treatment of iron deficiency without anemia in pregnant individuals after the 1st trimester (conditional recommendation, low certainty of evidence ⊕⊕○○).

Remark: The panel recognizes that the benefit of IV over oral iron may vary by clinical context and that additional prospective data are needed to strengthen this recommendation, specifically among high-risk populations.

➤ [Evidence Profile and Evidence to Decision Framework](#)

Severe anemia

Question: Should IV iron vs. Oral iron be used for adults with severe iron deficiency anemia?

Recommendation 7: The American Society of Hematology Guideline Panel *suggests* IV iron rather than oral iron for the treatment of adults with severe iron deficiency anemia (conditional recommendation, low certainty of evidence ⊕⊕○○).

Remarks:

- Patients who require rapid repletion to prevent blood transfusion and/or address severe cardiovascular and respiratory symptoms would particularly benefit from IV iron.
- Patients with severe anemia and concomitant conditions for which oral iron is ineffective or not tolerated, including individuals who are post-bariatric surgery or have other forms of malabsorption or blood loss, would also benefit from IV iron.

➤ [Evidence Profile and Evidence to Decision Framework](#)

Chronic blood loss

Question: In adults with iron deficiency anemia due to chronic blood loss, what is the effect of using initially IV iron vs oral iron?

Recommendation 8: The American Society of Hematology Guideline Panel *suggests* IV iron rather than oral iron for the treatment of adults with iron deficiency anemia due to chronic blood loss (conditional recommendation, moderate certainty of evidence ⊕⊕⊕○).

Remarks:

- IV iron therapy is most critical for adults with chronic blood loss and severe anemia and/or anticipated procedural blood loss.
- IV iron should be used as an important blood conservation strategy.

➤ [Evidence Profile and Evidence to Decision Framework](#)

Inflammation

Question: Should IV iron vs. Oral Iron be used for individuals with iron deficiency anemia and inflammation?

Recommendation 9: The American Society of Hematology Guideline Panel *suggests* IV iron rather than oral iron for adults with iron deficiency anemia and inflammatory bowel disease (conditional recommendation, low-certainty evidence ⊕○○○).

Remarks:

- This recommendation may apply to individuals with other inflammatory conditions and iron deficiency anemia.
- In patients with heart failure and chronic kidney disease or other chronic conditions for which professional society guidance exists, treatment of iron deficiency anemia should be guided by those recommendations.

➤ **Evidence Profile and Evidence to Decision Framework**

Total dose infusion versus multi-dose infusion

Question: Should TDI vs. MDI be used for iron deficiency with and without anemia?

Recommendation 10: The American Society of Hematology Guideline Panel *recommends* total dose infusion rather than multi-dose infusion for IV iron administration for the treatment of iron deficiency anemia in individuals who require rapid correction of anemia and replenishment of iron stores (strong recommendation, low certainty of evidence ⊕⊕○○).

Recommendation 11: The American Society of Hematology Guideline Panel *suggests* total dose infusion rather than multi-dose infusion for IV iron administration in people with iron deficiency with or without anemia requiring IV iron (conditional recommendation, low certainty of evidence ⊕⊕○○).

Remark: This recommendation places high value on patient preferences and convenience as well as efficient resource utilization.

➤ **Evidence Profile and Evidence to Decision Framework**

DRAFT