

New York State Poison Control Center's Antidote Stocking Recommendations*

Antidotes play a critical role in the care of poisoned or overdosed patients. The Poison Center (1-800-222-1222) is available 24/7, 365 days per year to provide assistance and expertise in managing poisoned patients.

The Upstate NY Poison Center and New York City Poison Control Centers have compiled a list of recommendations for antidote stocking.

{Table adapted with permission from Goldfrank's Toxicologic Emergencies 11th edition (pages 44-47)}

Drug Shortages

Drug shortages continue to occur and there are a number of antidotes that have been on shortage.

For the most up to date information about drug shortages:

- The FDA website and app can be searched for a specific drug in shortage. (<https://www.fda.gov/drugs/drug-safety-and-availability/drug-shortages>)
- The American Society of Health System Pharmacists (ASHP) also manages a drug shortage database and occasionally recommends the use of other agents as substitutions. (<https://www.ashp.org/drug-shortages/current-shortages>)

Antidote	Stocking Recommendations (24 hours)	Immediate Availability Recommended (Y/N)	Availability Recommended < 60 min (Y/N)	Considerations
Acetylcysteine (IV), grams	20% IV Solution 6 x 30 mL	N	Y	
Acetylcysteine (PO), grams	20% ORAL Solution 7 x 30 mL PLUS 7 x 10 mL	N	Y	
Andexanet Alfa	18 x 100 mg vials	Y	Y	You should refer to your institution's plan to reverse bleeding in a patient on anticoagulants. You may or may not choose to carry specific 'antidotes' such as idarucizumab or andexanet alfa
Atropine	165 mg	Y	Y	
Calcium chloride	1 g/10 ml - 10 vials	Y	Y	
Calcium gluconate	1 g/10 ml - 30 vials	Y	Y	
Calcium disodium edetate	2 x 5 mL, 200 mg/ml	N	N	Each vial costs > \$20,000 per vial. If you don't stock this chelator, you should have a mechanism in place to obtain it within 12 - 24 hours if needed. Succimer should be available. -How to order:

				https://btgsp.com/en-us/special-pages/edta
Crotalidae-polyvalent immune Fab [ovine] {CroFab®}	18 vials	N	Y	The recommendation is to stock either Crotalidae FAB or FAB2, not both
Crotalidae-immune F(ab') ₂ [equine] {Anavip®}	20 vials	N	Y	The recommendation is to stock either Crotalidae FAB or FAB2, not both
Dantrolene	Ryanodex 4 x 250 mg vials OR 50 x 20 mg vials	Y	Y	
Deferoxamine	12 x 500 mg vials	N	Y	
Digoxin immune FAB**	10 vials	Y	Y	
Dimercaprol (BAL)	8 x 3 mL, 100 mg/ml	N	Y	-The company that manufactured BAL is no longer in business. It is unclear if BAL will become available from a different company. -Succimer should be available
D-Penicillamine				-This chelator can be used as an alternative for lead poisoning if no other chelators are available -Succimer should be

				available and is preferred
Fomepizole	4 x 1.5 mL, 1 g/ml	N	Y	
Flumazenil	2 x 10 ml, 0.1 mg/ml	Y	Y	
Glucagon	20 x 1 mg	Y	Y	
Glucarpidase**	5 x 1000 units/vial	N	N	-This is the antidote for catastrophic methotrexate poisoning or inadvertent overdoses of methotrexate. -It is very costly -Unless you are a cancer center, you likely won't carry this antidote but should have a system in place to obtain it if needed. -Leucovorin MUST also be available and typically before glucarpidase
Hydroxocobolamin	2 x 5 g	Y	Y	Preferred antidote for cyanide toxicity
Idarucizumab**	2 x 50 mL, 2.5 g/50 ml	Y	Y	You should refer to your institution's plan to reverse bleeding in a patient on anticoagulants. You may or may not choose to carry specific 'antidotes' such as idarucizumab or andexanet alfa
Insulin for High Dose Insulin/Euglycemia	17 vials of 100 units/ml (10 ml vials) regular	Y	Y	-High Dose Insulin Euglycemia therapy (HIET)

Therapy (This recommendation is to treat one 70 kg patient on 10 units/kg/hour for 24 hours)**	insulin			is used for calcium channel blocker/beta blocker toxicity -LD 1 unit/kg IV bolus followed by MD 1 to 10 units/kg/h titrated every 15 min -Use insulin 10 unit/ml concentration instead of traditional 1 unit/mL to minimize fluid overload -Start supplemental glucose unless initial glucose >300 mg% -Maintain minimum K in 2.8 to 3.2 mEq/L range
Leucovorin**	4 x 50 mL, 10 mg/ml	N	Y	
Levocarnitine (IV)	15 x 5 mL, 1 g/5 ml	N	Y	
Levocarnitine (PO)	6000 mg			
Lipid emulsion (IV), milliliters (Intralipid)	1 x 1000 ml 20%	Y	Y	We do suggest that you stock Intralipid
Methylene blue	12 x 10 mL, 5 mg/mL	Y	Y	
Naloxone	10 x 1 ml, 0.4 mg/ml 30 x 2 ml, 1 mg/mL or 6 x 4 mg/10 ml (10ml)	Y	Y	
Octreotide	5 x 1 mL, 50 mcg/ml	N	Y	
Physostigmine	4 x 2 mL, 1 mg/ml	Y	Y	-The company that manufactured physostigmine is no longer in business. It is

				unclear if this product will be manufactured from another company. -Rivastigmine is a potential substitute during the physostigmine shortage. Consult with your regional poison center.
Phytonadione	10 x 1 mL, 10 mg/ml; 20 x 5 mg tablets	Y	Y	
Pralidoxime (2-PAM)	18 x 1 g vials			NOTE that in the case of many patients presenting with cholinergic toxicity or one severely poisoned patient, there are Mark-I kits (autoinjectors containing both atropine and pralidoxime) stored as Chem-Paks.
Protamine**	4 vials 50 mg/5 mL	Y	Y	
4 factor prothrombin complex concentrate	5 x 1000 Units	Y	Y	
Pyridoxine	10 grams 100 x 1 ml, 100 mg/ml	Y	Y	The initial dose of pyridoxine for Isoniazid (INH) poisoning is 70 mg/kg (max 5 grams) IV and may be repeated once.
Sodium bicarbonate	10 vials or syringes	Y	Y	
Sodium nitrite	2 x 10 ml, 30 mg/ml	Y	Y	This should only be used as a cyanide antidote when

				hydroxocobolamin is NOT available It should NEVER be given to a smoke inhalation patient
Sodium thiosulfate	2 x 50 ml, 250 mg/ml	Y	Y	
Succimer (DMSA)	30 x 100 mg capsules	N	Y	
Thiamine	9 x 2 ml, 100 mg/ml	Y	Y	
Uridine triacetate, grams	4 x 10-g packets	N	N	-This is the antidote for 5-fluorouracil toxicity. It should be given as soon as possible after overdose and is effective up to 96 hours after overdose. -It is very costly -Unless you are a cancer center, you likely won't carry this antidote but should have a system in place to obtain it if needed.

** : Store in refrigerator: For full storage details, confirm with the package insert and/or Goldfrank's Toxicologic Emergencies SC-1 Table

**We realize that depending on your geographic location or size of your hospital, that some antidotes will not be stocked. However, we strongly recommend that you have a process in place to obtain those rare antidotes promptly in the event you have a patient requiring them.

Reference:

Dart RC, Goldfrank LR, Erstad BL et al. Expert Consensus Guidelines for Stocking of Antidotes in Hospitals That Provide Emergency Care. *Ann Emerg Med* 2018; 71:314-325.

Goldfrank's Toxicologic Emergencies 11th edition; Mc-Graw Hill Education. Chapter SC1. Principles of Antidote Stocking. Pages 42-48.