Erythropoiesis-Stimulating Agents for Anemia of Chronic Kidney Disease – Order form

REDINGTON-FAIRVIEW GENERAL HOSPITAL
(207) 474-5121 / WWW.RFGH.NET
Skowhegan, Maine 04976

Weight: _____kg Height: _____inches

Chronic kidney disease stage: _____ GFR_____
When documenting the encounter that resulted in decision to treat anemia of CRD, that note & all subsequent notes referring to CRD must include the stage.

Eligible CKD stages: GFR (ml/min/1.73 m2)
stage III – 30-59
stage IV – 15-29
stage V - <15 or dialysis

LABS and monitoring: All lab results to provider and Oncology Department.
Baseline: CBC (within 1 week prior to starting therapy), erythropoietin level, TIBC, serum iron level, Transferrin, Ferritin level, B12, folic acid level.

- All required if not already obtained.
- If %Sat < 20%, or serum Ferritin < 100 micrograms/L consider treatment for Iron Deficiency Anemia. See *Injectable iron order form*.

Every 3 months: Ferritin and % transferrin saturation ************

DOSE:
DARBEPOETIN (Aranesp): _____mcg SQ **every___ 2 weeks, ____3 weeks, ____4 weeks**
Recommended starting dose 0.45 mcg/kg every 4 weeks, rounded to prefilled dose size.
Available pre-filled doses: 25mcg, 40mcg, 60mcg, 100mcg, 150mcg, 200mcg, 300mcg, 500mcg

Prior to each treatment: Hgb/Hct no sooner than 1 day prior.
Blood pressure day of treatment.

If Hgb <_____ (max 10) **initiate Erythropoietin therapy.**

Target Hgb is _____ to _____ g/dL Usual 10-11.5*

*Consider higher in younger patients with fewer comorbidities whose symptoms do not respond to Hgb 10-11.5; Max 13)

- **HOLD** and contact provider for Hgb ≥11, Hct ≥34, SBP ≥160, or DBP ≥ 100
- Optimal rate of correction is 1-2 g/dL over 4 weeks
- If Hgb > maximum target, hold therapy and:
  - Repeat Hgb & Hct every 2 weeks until Hgb < maximum target.Resume therapy and monthly labs when Hgb < maximum target.
    _____ **Resume** erythropoietin therapy at **25% dose reduction** **-or-**
    _____ mcg Aranesp SQ every _____ weeks

If Hgb not increased by at least one gm/dl, 4 weeks after beginning erythropoietin, contact provider for dose increase

REQUIRED Prior Authorization Number: _____ [ ] pending [ ] complete [ ] not needed*
*If not needed is chosen, date, time and name of person at health insurer who authorized.

Date:_____ Time:_____ Duration of authorization:_____

Checklist for non-RFGH credentialed providers:
[ ] Problem list, current medication and allergies attached
[ ] Provider to provider communication is required. If the patient has a Primary Care Provider at RFGH, please contact that PCP. Otherwise, call (207) 474-5121 and ask to speak to hospitalist .
Contacted provider:_____

FAX completed to RFGH infusion CLINIC 207-858-2415; Phone# 207-858-2119

Provider_____ Date_____ time_____

Printed name_____ Phone # _____

RFGH Co-signature _____

Date_____ time_____
if above non-RFGH Revised: 4/25

Label or
Patient name_____

Date of birth_____ Phone #_____