

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

Skowhegan, Maine 04976

Weight: _____ kg Height: _____ inches	
Chronic kidney disease stage: _____ GFR _____ <i>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.</i>	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. <u>Baseline:</u> 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 <i>Injectable iron order form</i>.	
<u>Every 3 months:</u> 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 <u>Prior to each treatment:</u> 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* 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	*Consider higher in younger patients with fewer comorbidities whose symptoms do not respond to Hgb 10-11.5; Max 13)
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 – attached: [] Problem list [] Current medication and allergies list	
FAX completed to RFGH Oncology Clinic 207-858-2131. Oncology contact 207-858-2119	

Provider _____ Date _____ time _____

Printed name _____ Phone # _____

Revised: 9/25

Patient _____

dob _____ phone # _____