Weight: ___________ kg  Height: ___________ cm

Allergies: ________________________________________________________________

Diagnosis Code: __________________________________________________________

Treatment Start Date: ___________  Patient to follow up with provider on date: ___________

**This plan will expire after 365 days at which time a new order will need to be placed**

** PHARMACY MANAGED PROTOCOL / OPT OUT: (Must check one) **
- Order Epoetin Alfa-epbx (Retacrit) per OHSU Pharmacist managed dosing protocol
- Provider managed (Opt out of Pharmacy managed protocol)

** INDICATION: (Must check one) **
- Chemotherapy-induced anemia
  For patients with chemotherapy-induced anemia: The medical record must document the provider's rationale for determining the anemia is "chemotherapy-induced." Anemia must be secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, or lymphocytic leukemia. Treatment should be limited to the 8 weeks following myelosuppressive chemotherapy.

- Symptomatic anemia associated with myelodysplastic syndrome (MDS)
  For patients with symptomatic anemia from MDS: The patient must be symptomatic and his/her life expectancy must be >3 months. The medical record must display documentation that a bone marrow biopsy has been reviewed by a provider and is consistent with the diagnosis of MDS. The marrow blast count must be <5%.

- Anemia of Chronic Kidney Disease (CKD)
  For patients with anemia of CKD: The medical record must display documentation that anemia is clearly attributed to a CKD diagnosis. The specific CKD stage must be moderate (stage III) to end stage.

** GUIDELINES FOR ORDERING:**
1. Send FACE SHEET and H&P or most recent chart note.
2. Hemoglobin and hematocrit must be obtained within 1 week of therapy initiation. Hemoglobin must be < 10 g/dL or hematocrit must be < 30% prior to initiation.
3. Serum ferritin and transferrin saturation (TSAT) must be performed every 3 months during erythropoiesis stimulating agent (ESA) treatment (serum ferritin >100 ng/mL, and TSAT ≥ 20%). Therapy with ESA may continue only if hemoglobin DOES NOT equal or exceed 11 g/dL.
4. All patients must be negative when evaluated for blood loss, hemolysis, and bone marrow fibrosis prior to initiation of therapy. Providers must assess and replete iron, folate, and Vitamin B12 prior to any treatment with ESA.
5. Patients cannot receive Iron Sucrose (VENOFER) and/or Vitamin B12 on the same day as ESA treatment. Patients may be on prophylactic oral iron supplementation concurrent with ESA treatment as long as supplementation for the prevention of iron deficiency is necessary due to ESA therapy alone.
LABS:
- Hemoglobin & Hematocrit, Routine, ONCE, every visit
- Labs already drawn. Date: __________ (Labs scanned with orders)

NURSING ORDERS:
1. Patients cannot receive Iron Sucrose (VENOFER) and/or Vitamin B12 on the same day as ESA treatment.
2. Do not obtain ferritin or transferrin saturation (TSAT) on the same day as ESA treatment.
3. TREATMENT PARAMETERS – Hemoglobin and hematocrit must be obtained within 1 week of therapy initiation. Hemoglobin must be less than 10 g/dL or hematocrit must be less than 30% prior to initiation. Hemoglobin must be less than 11 g/dL for maintenance. Ferritin should be greater than 100 ng/mL and transferrin saturation should be greater than or equal to 20%. Hold treatment and call provider if lab parameters are not met or if blood pressure is greater than 180 mm Hg systolic or 100 mm Hg diastolic.

MEDICATIONS: (must check one if provider managed - opt out of pharmacy managed protocol)

<table>
<thead>
<tr>
<th>Indication</th>
<th>Weight</th>
<th>Dose level 0 (Starting Dose)</th>
<th>Dose Decrease</th>
<th>Dose Increase</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Dose level -1</td>
<td>Dose level -2</td>
<td>Dose level +1</td>
<td>Dose level +2</td>
</tr>
<tr>
<td>MDS ≥ 60 kg</td>
<td>≥ 60 kg</td>
<td>40,000 units weekly</td>
<td>30,000 units weekly</td>
<td>22,000 units weekly</td>
<td>50,000 units weekly</td>
</tr>
<tr>
<td></td>
<td>&lt; 60 kg</td>
<td>24,000 units weekly</td>
<td>18,000 units weekly</td>
<td>13,000 units weekly</td>
<td>40,000 units weekly</td>
</tr>
<tr>
<td>Chemo induced ≥ 60 kg</td>
<td>≥ 60 kg</td>
<td>40,000 units weekly</td>
<td>30,000 units weekly</td>
<td>22,000 units weekly</td>
<td>60,000 units weekly</td>
</tr>
<tr>
<td></td>
<td>&lt; 60 kg</td>
<td>24,000 units weekly</td>
<td>18,000 units weekly</td>
<td>13,000 units weekly</td>
<td>40,000 units weekly</td>
</tr>
<tr>
<td>CKD (no HD) ≥ 60 kg</td>
<td>≥ 60 kg</td>
<td>20,000 units every 2 weeks</td>
<td>14,000 units every 2 weeks</td>
<td>10,000 units every 2 weeks</td>
<td>24,000 units every 2 weeks</td>
</tr>
<tr>
<td></td>
<td>&lt; 60 kg</td>
<td>10,000 units every 2 weeks</td>
<td>8,000 units every 2 weeks</td>
<td>6,000 units every 2 weeks</td>
<td>12,000 units every 2 weeks</td>
</tr>
<tr>
<td>CKD on dialysis</td>
<td>Managed in dialysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.
Epoetin alfa-epbx (RETACRIT), subcutaneous, ONCE
Initiate first dose within 1 week of obtaining baseline labs.

Chemotherapy-induced anemia:
☐ 40,000 units weekly (for ≥ 60 kg)
☐ 24,000 units weekly (for < 60 kg)

Symptomatic anemia associated with MDS:
☐ 40,000 units weekly (for ≥ 60 kg)
☐ 24,000 units weekly (for < 60 kg)

Anemia of Chronic Kidney Disease:
☐ 20,000 units every 2 weeks (for ≥ 60 kg)
☐ 10,000 units every 2 weeks (for < 60 kg)

Fixed dose regimens: (must check one)
☐ 2,000 units
☐ 3,000 units
☐ 4,000 units
☐ 10,000 units
☐ 20,000 units
☐ 40,000 units

Interval:
☐ Once
☐ Weekly x _____ weeks
☐ ____ times per week x ____ week

By signing below, I represent the following:
I am responsible for the care of the patient (who is identified at the top of this form);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ __________________ (check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon);

My physician license Number is # __________________ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: ___________________________ Date/Time: __________________
Printed Name:_____________________________ Phone: ________________ Fax: ______________
OLC Central Intake Nurse:
Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

- **Beaverton**
  OHSU Knight Cancer Institute
  15700 SW Greystone Court
  Beaverton, OR 97006
  Phone number: 971-262-9000
  Fax number: 503-346-8058

- **Gresham**
  Legacy Mount Hood campus
  Medical Office Building 3, Suite 140
  24988 SE Stark
  Gresham, OR 97030
  Phone number: 971-262-9500
  Fax number: 503-346-8058

- **NW Portland**
  Legacy Good Samaritan campus
  Medical Office Building 3, Suite 150
  1130 NW 22nd Ave.
  Portland, OR 97210
  Phone number: 971-262-9600
  Fax number: 503-346-8058

- **Tualatin**
  Legacy Meridian Park campus
  Medical Office Building 2, Suite 140
  19260 SW 65th Ave.
  Tualatin, OR 97062
  Phone number: 971-262-9700
  Fax number: 503-346-8058

Infusion orders located at: [www.ohsuknight.com/infusionorders](http://www.ohsuknight.com/infusionorders)