Oregon Health & Science University Hospital and Clinics Provider's Orders

PO7071

ADULT AMBULATORY INFUSION ORDER

Darbepoetin Alfa (ARANESP) Injection

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

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****

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 detailing treatment indication and plan.**
2. Hemoglobin and hematocrit must be obtained within 1 week of therapy initiation. Hemoglobin must be less than 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 meets maintenance treatment parameters per indication.
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 same day as ESA treatment.
2. Do not obtain ferritin or transferrin saturation (TSAT) on the same day as ESA treatment.
3. TREATMENT PARAMETERS –
    a. Hemoglobin and hematocrit must be obtained within 1 week of each individual ESA treatment.
    b. Hemoglobin must be less than 10 g/dL or hematocrit must be less than 30% prior to initiation.
    c. For maintenance dosing, hemoglobin must be:
        i. Chemotherapy induced anemia: Hgb < 10 g/dL
        ii. Anemia due to MDS: Hgb < 12 g/dL
        iii. Anemia due to CKD: Hgb < 11 g/dL
        iv. Other: Hgb < _____ g/dL
    d. Ferritin should be greater than or equal to100 ng/mL and transferrin saturation should be greater than or equal to 20%.
    e. 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)***

Darbepoetin alfa (ARANESP), subcutaneous, ONCE
Initiate first dose within 1 week of obtaining baseline labs.

PHARMACY MANAGED PROTOCOL / OPT OUT: ***(Must check one)***

- ○ Pharmacist managed dosing protocol **(OHSU infusion centers only)**. Do NOT indicate specific dose below, pharmacy to manage per institutional protocol.
- ○ Provider managed dosing (indicated dosing below)
  Fixed dose regimen

Fixed dose regimen: (if provider managed dosing, must check one)

- ☐ 40 mcg
- ☐ 60 mcg
- ☐ 100 mcg
- ☐ 150 mcg
- ☐ 200 mcg
- ☐ 300 mcg

Interval:

- ☐ Once
- ☐ Every ____ weeks x ____ doses

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Darbepoetin								
Indication	**Weight**	**Dose Level 0 (Starting Dose)**	**Dose Decrease**		**Dose Increase**			
			Dose level -1	**Dose level -2**	**Dose level +1**	**Dose level +2**	**Adjunctive agent**	**Notes**
MDS	≥ 60 kg	300 mcg every 2 weeks	200 mcg every 2 weeks	150 mcg every 2 weeks	400 mcg every 2 weeks	500 mcg every 2 weeks	By week 12 if no response, contact provider to add GCSF 300 mcg 1-3x per week	By week 16 if no increase in Hgb by 1.5 or reach target of 10-12 g/dL or decrease in transfusion needs discontinue
	< 60 kg	200 mcg every 2 weeks	150 mcg every 2 weeks	100 mcg every 2 weeks	300 mcg every 2 weeks	400 mcg every 2 weeks		
Chemo induced	≥ 60 kg	300 mcg every 2 weeks	200 mcg every 2 weeks	150 mcg every 2 weeks	400 mcg every 2 weeks			By week 8 if no improvement in Hgb, maintain lowest dose to avoid transfusions, if no improvement in transfusion requirements discontinue
	< 60 kg	200 mcg every 2 weeks	150 mcg every 2 weeks	100 mcg every 2 weeks	300 mcg every 2 weeks			
CKD (no HD)	≥ 60 kg	40 mcg every 4 weeks	25 mcg every 4 weeks	20 mcg every 4 weeks	60 mcg every 4 weeks			By week 12 if no improvement in Hgb, maintain lowest dose to avoid transfusions, if no improvement in transfusion requirements discontinue
	< 60 kg	20 mcg every 4 weeks	15 mcg every 4 weeks	10 mcg every 4 weeks	30 mcg every 4 weeks			
CKD on dialysis	Managed in dialysis							

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:** _____

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Central Intake:

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

☐ **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

☐ **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

☐ **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