**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.

"ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE."
LABS:
- Hemoglobin & Hematocrit, Routine, ONCE, every visit
- Ferritin, once clinic collect, comment as needed if not resulted in last 90 days, interval quarterly
- Iron and TIBC, once clinic collect, comment as needed if not resulted in last 90 days, interval quarterly
  - 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. OK to give erythropoiesis-stimulating agents on the same day as blood transfusions.
4. 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 less than 10 g/dL
      ii. Anemia due to MDS: Hgb less than 12 g/dL
      iii. Anemia due to CKD: Hgb less than or equal to 11 g/dL
      iv. Other: Hgb less than __________ g/dL
   d. Ferritin should be greater than or equal to 100 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)
- 25 mcg
- 40 mcg
- 60 mcg
- 80 mcg
- 100 mcg
- 150 mcg
- 200 mcg
- 300 mcg
- 400 mcg
- 500 mcg

Interval:
- Once
- Every ____ weeks x ____ doses
# Darbepoetin

<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>Adjunctive agent</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dose level -1</td>
<td>Dose level -2</td>
<td>Dose level +1</td>
<td>Dose level +2</td>
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<tr>
<td>MDS</td>
<td>≥ 60 kg (or flat dose)</td>
<td>300 mcg every 2 weeks</td>
<td>200 mcg every 2 weeks</td>
<td>150 mcg every 2 weeks</td>
<td>400 mcg every 2 weeks</td>
<td>500 mcg every 2 weeks</td>
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<tr>
<td></td>
<td>&lt; 60 kg</td>
<td>200 mcg every 2 weeks</td>
<td>150 mcg every 2 weeks</td>
<td>100 mcg every 2 weeks</td>
<td>300 mcg every 2 weeks</td>
<td>400 mcg every 2 weeks</td>
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<tr>
<td>Chemo induced</td>
<td>≥ 60 kg (or flat dose)</td>
<td>300 mcg every 2 weeks</td>
<td>200 mcg every 2 weeks</td>
<td>150 mcg every 2 weeks</td>
<td>400 mcg every 2 weeks</td>
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<tr>
<td></td>
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<td>200 mcg every 2 weeks</td>
<td>150 mcg every 2 weeks</td>
<td>100 mcg every 2 weeks</td>
<td>300 mcg every 2 weeks</td>
<td></td>
</tr>
<tr>
<td>CKD (no HD)</td>
<td>≥ 60 kg (or flat dose)</td>
<td>40 mcg every 4 weeks</td>
<td>25 mcg every 4 weeks</td>
<td>20 mcg every 4 weeks</td>
<td>60 mcg every 4 weeks</td>
<td>80 mcg every 4 weeks</td>
</tr>
<tr>
<td></td>
<td>&lt; 60 kg</td>
<td>25 mcg every 4 weeks</td>
<td>20 mcg every 4 weeks</td>
<td>12.5 mcg every 4 weeks</td>
<td>40 mcg every 4 weeks</td>
<td>60 mcg every 4 weeks</td>
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</table>
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: _______________

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