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 greater than 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 less than 5% and serum EPO must be less than or equal to 500 mU/mL.

☐ 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. At OHSU Infusion centers, iron studies not meeting parameter cannot be bypassed with an override. Providers wanting to pursue treatment for patients with iron studies below treatment parameters should contact ambulatory consult pharmacist for next steps.
3. Erythropoietin treatment plans administered at OHSU infusion centers may be managed by a pharmacist. Refer to Guidelines for Ordering 2 below.
4. Erythropoietin treatment plans administered at non-OHSU infusion centers will be managed by the ordering provider.
5. 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.
6. 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.

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7. 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.
8. 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
- 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. Initiation dose: hemoglobin and hematocrit must be obtained within 1 week. Hemoglobin must be less than 10 g/dL or hematocrit must be less than 30% prior to initiation.
    b. Maintenance doses: hemoglobin must be obtained within 72 hours of each individual dose. 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
    c. Ferritin must be greater than or equal to 100 ng/mL and transferrin saturation must be greater than or equal to 20%. Ferritin and transferrin saturation cannot exceed 90 days from each individual dose.
    d. Hold treatment and call provider (or infusion pharmacist if pharmacy managed) 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)***

Epoetin alfa-epbx (RETACRIT), 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 regimens: (must check one)

- ☐ 2,000 units

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- ☐ 3,000 units
- ☐ 4,000 units
- ☐ 10,000 units
- ☐ 20,000 units
- ☐ 40,000 units

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

Epoetin								
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 (or flat dose)	40,000 units weekly	30,000 units weekly	22,000 units weekly	50,000 units weekly	60,000 units weekly	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	24,000 units weekly	18,000 units weekly	14,000 units weekly	40,000 units weekly	60,000 units weekly		
Chemo induced	≥ 60 kg (or flat dose)	40,000 units weekly	30,000 units weekly	22,000 units weekly	60,000 units weekly			By week 8 if no improvement in Hgb, maintain lowest dose to avoid transfusions, if no improvement in transfusion requirements discontinue
	< 60 kg	24,000 units weekly	18,000 units weekly	14,000 units weekly	40,000 units weekly			
CKD (no HD)	≥ 60 kg (or flat dose)	20,000 units every 2 weeks	14,000 units every 2 weeks	10,000 units every 2 weeks	24,000 units every 2 weeks	30,000 units every 2 weeks		By week 12 if no improvement in Hgb, maintain lowest dose to avoid transfusions, if no improvement in transfusion requirements discontinue
	< 60 kg	10,000 units every 2 weeks	8,000 units every 2 weeks	6,000 units every 2 weeks	12,000 units every 2 weeks	16,000 units every 2 weeks		

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HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

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:** _____

INFUSION REFERRAL TEAM Phone (providers only) (971) 262-9645 Fax completed orders to (503) 346-8058 *Infusion orders located at:* *www.ohsuknight.com/infusionorders*	☑ **Please indicate the patient's preferred clinic location below**	
	☐ **BEAVERTON** OHSU Knight Cancer Institute	15700 SW Greystone Court Beaverton OR 97006
	☐ **NW PORTLAND** Legacy Good Samaritan campus	Medical Office Building 3 – Suite 150 1130 NW 22nd Ave, Portland OR 97210
	☐ **GRESHAM** **Legacy Mount Hood campus**	Medical Office Building 3 – Suite 140 24988 SE Stark, Gresham OR 97030
	☐ **TUALATIN** **Legacy Meridian Park campus**	Medical Office Building 2 – Suite 140 19260 SW 65th Ave, Tualatin OR 97062