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

PO9031

ADULT AMBULATORY INFUSION ORDER

Darbepoetin Alfa (ARANESP) Maintenance for Anemia of CKD

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****
****This order set is for MAINTENANCE DOSING ONLY. Patients should have received first dose via the INITIATION order set with anemia of CKD selected as indication****
****If your patient has an ONCOLOGY INDICATION, DO NOT use this form. Please use the form for maintenance in oncology patients****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. OHSU's formulary erythropoiesis stimulating agent (ESA) is darbepoetin alfa (ARANESP). All orders for epoetin alfa (PROCRIT) will be converted to darbepoetin alfa using equivalent therapeutic interchange dosing listed in the table below. Providers who prefer to use epoetin alfa must specify a reason for its use and utilize an alternate ordering form.
3. Patients receiving concurrent treatment with Iron Sucrose (VENOFER) and/or Vitamin B12 cannot receive ESA treatment on the same day. 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.
4. Serum ferritin and transferrin saturation (TSAT) must be performed every month during initial (ESA) treatment and at least every 3 months during stable ESA treatment (serum ferritin >100 ng/mL, and TSAT >20%). Therapy with darbepoetin alfa may continue **only if hemoglobin DOES NOT exceed 11 g/dL**.
5. **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

LABS:

- ☐ Hemoglobin & Hematocrit, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ CMP, Routine, ONCE, (every 12 weeks) or every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Ferritin (serum), Routine, ONCE, (every 12 weeks) or every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Iron and TIBC (serum), Routine, ONCE, (every 12 weeks) or every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Labs already drawn. Date: _____

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MEDICATIONS:

- **darbepoetin alfa (ARANESP), subcutaneous, ONCE**
  Pharmacist will round dose to nearest vial size if within 10% of original dose during verification

  Weight based regimen:
  Dose
  ☐ 0.45 mcg/kg = _____ mcg
  Interval:
  - Every _____ weeks x _____ doses

  Fixed dose regimens:
  Dose:
  ☐ 25 mcg
  ☐ 40 mcg
  ☐ 60 mcg
  ☐ 100 mcg
  ☐ 150 mcg
  ☐ 200 mcg
  ☐ 300 mcg
  Interval:
  - Every _____ weeks x _____ doses

OTHER:

Conversion from epoetin alfa (PROCRIT) to darbepoetin alfa (ARANESP): Initial adult dosing

Epoetin alfa dose (units/week)	Darbepoetin alfa dose (mcg/week)
<1500	6.25
1500-2499	6.25
2500-4999	12.5
5000-10,999	25
11,000-17,999	40
18,000-33,999	60
34,000-89,999	100
≥90,000	200

In patients receiving epoetin alfa 2-3 times weekly, darbepoetin should be given once weekly. If epoetin is administered once weekly, darbepoetin should be given once every 2 weeks. Darbepoetin dosing every 2 weeks should be determined by adding the 2 weekly epoetin alfa doses, then convert to appropriate corresponding darbepoetin dose. Doses should be titrated to hemoglobin response thereafter

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NURSING ORDERS:

1. Patients receiving concurrent treatment with Iron Sucrose (VENOFER) and/or Vitamin B12 cannot receive ESA treatment on the same day.
2. TREATMENT PARAMETERS – Hold treatment and call provider if hemoglobin is greater than 11, serum ferritin is less than or equal to 100 ng/mL, transferrin saturation is less than or equal to 20% or if blood pressure is greater than 180 systolic or 100 diastolic.
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

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:** _____

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

☐ TUALITY HEALTHCARE
An OHSU Partner

Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ MCMC
MID-COLUMBIA MEDICAL CENTER
A Planetree Patient-Centered Hospital

Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
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