

ORANGE REGIONAL MEDICAL CENTER
Physician Order Form

KONGAL, WALTER

DOB 4/10/31.

DO NOT USE ABBREVIATIONS:

U MS MSO₄ MgSO₄ QD μ g
IU SC SQ SL QOD

Patient Label

OUTPATIENT DARBEPOETIN (Aranesp[®]) Erythropoietic Stimulating Agent (ESA) Order Form

Initial Hemoglobin (Hgb)/Hematocrit (Hct) Date/level: _____
Current Hgb: _____ Hct: _____

Wt: _____ kg

DIAGNOSIS (Check one):

☐ Chemotherapy induced anemia

Hemoglobin (Hgb)/ Hematocrit (Hct) must be < 10 g/dL and < 30%
Darbepoetin initial dose \leq 2.25 mcg/kg/week
On week 4 dose may be increased by 25% if Hgb/Hct rise is < 1/3.
By week 8 discontinue treatment unless a rise of 1/3 is documented

☒ Chronic Kidney Disease (CRD) not on dialysis

For chronic kidney disease creatinine \geq 3 and CrCl < 60 mL/min
Monitor to ensure transferrin saturation > 20% and/or serum ferritin > 100 ng/mL

Hgb Aranesp

for Hgb \geq 11 g/dL

☐ End Stage Renal Disease (ESRD) on dialysis

Monitor to ensure transferrin saturation > 20% and/or serum ferritin > 100 ng/mL

☐ HIV/AIDS anemia induced by zidovudine or other nucleoside reverse transcriptase inhibitors

☐ Anemia related to myelodysplastic syndrome (MDS) excluding AML and CML

Bone marrow biopsy < 5% blasts
Erythropoietin level 100 or less
After 2 months of treatment consider discontinuing if there is no significant increase in Hgb/Hct and/or decreased transfusions

☐ Treatment of anemia of selected chronic diseases (check one below)

- ☐ Rheumatoid arthritis,
- ☐ Systemic lupus erythematosus
- ☐ Inflammatory bowel diseases
- ☐ Hepatitis C undergoing treatment

Initial Hgb/Hct must be < 10 g/dL and < 30%. For all uses other than chemotherapy induced anemia, titrate dose of darbepoetin to maintain a target Hgb of 10-12 g/dL and Hct of 30-36% by appropriate timed dose adjustment.

Date of last ESA agent: _____ Do not give Darbepoetin more frequently than once weekly

Drug	Dose (mcg)	Route	Frequency	RN/Time
Darbepoetin (Aranesp [®])	40 mcg	<input checked="" type="checkbox"/> SubQ <input type="checkbox"/> IV	weekly	

Print Last Name: Rama Suman V
Physician Signature: [Signature]
Date: 9/1/17 Time: 2:20 PM

Print Last Name: _____
Nurse Signature: _____ Date: _____
RBV INIT Time: _____ Faxed ☐ Time Faxed _____