ORANGE REGIONAL MEDICAL CENTER
Physician Order Form

Mordaghian, Yeghiche DOB: 11/17/40

DO NOT USE ABBREVIATIONS:

U	MS	MSO_4	$MgSO_4$	QD	µg
IU	SC	SQ	SL	QOD	

OUTPATIENT DARBEPOETIN (Aranesp®) Erythropoetic Stimulating Agent (ESA) Order Form

Initial Hemoglobin (Hgb)/Hematocrit (Hct) Date/level: _____ Wt: 64 kg
Current Hgb: _____ Hct: _____

DIAGNOSIS (Check one):

☐ **Chemotherapy induced anemia**
- Hemoglobin (Hgb)/ Hematocrit (Hct) must be < 10 g/dL and < 30%
- Darbepoetin initial dose ≤ 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 ≥ 3 and CrCl < 60 mL/min
- Monitor to ensure transferring saturation > 20% and/or serum ferritin > 100 ng/mL

☐ **End Stage Renal Disease(ESRD) on dialysis**
- Monitor to ensure transferring 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®)	every 4 mcg 2 weeks	☒ SubQ ☐ IV	every 2 weeks	

Print Last Name: Ramaswamy
Physician Signature: [signature]
Date: 10/29/18 Time: 4 pm

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