CCU-3341-FRM
REV 0 06.07.10

# Conway Medical Center
**Conway, South Carolina**

## PHYSICIAN'S ORDERS

## Argatroban Infusion Dosing Protocol Orders (CCU/Telemetry)

Center Patient Admission Label Here

Drug Allergies:

**Weight (Kg): _____** Height: _____

**Indication:** anticoagulant/Thrombin inhibitor used for prophylaxis or treatment of thrombosis in patients with Heparin-induced Thrombocytopenia (HIT). Place Argatroban monitoring Flowsheet in chart.

**Laboratory Orders:**

Obtain Stat: PTT, PT / INR, CBC, and Liver Profile for HIT therapy

Repeat PTT every 2 hrs until in **GOAL** range X 2 consecutively; then PTT daily while on IV Argatroban

☐ If newly diagnosed heparin induced thrombocytopenia, daily CBC. Notify physician when platelet counts are greater than 100,000 or returns to patient's baseline.

**If patient's initial PTT greater than 95 or INR greater than 2.5 do not start Argatroban and notify MD.**

Discontinue all Warfarin orders and all orders for Heparin products (include flushes, Lovenox and Arixtra)

Wait 4 hrs before administering Argatroban if Heparin has been given.

Wait 12 hrs before administering Argatroban if low molecular weight Heparin (Lovenox) or Arixtra have been given

Discontinue IM injections while infusing Argatroban (notify MD if needed.)

**Adult Dosing for HIT (Argatroban 250 mg in 250 ml $D_5W$ – concentration = 1000 mcg/ml):**

☐ Normal liver function, start IV Argatroban drip at **2 mcg/kg/min (_____ml/hr)**

☐ Child-Pugh Score =7 or more / Combined hepatic/renal dysfunction, start IV Argatroban drip at **0.5 mcg/kg/min (_____ml/hr)**

The GOAL is to obtain a PTT value in range 50-90 seconds.

Dosing not to exceed 10mcg/kg/minute or aPTT of 100 seconds.

**IV Argatroban drip adjustments to be made as per the Dose Adjustment Chart on flow sheet.**

| Initial infusion rate in **ml/hr** (*No max rate. For wt > 140kg, contact pharmacy if needed to calculate rate) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Wt (Kg) | Under 40 | 40 | 50 | 60 | 70 | 80 | 90 | 100 | 110 | 120 | 130 | 140 |
| 2 mcg/kg/min | 5 | 5 | 6 | 7 | 8 | 9 | 10 | 12 | 13 | 14 | 15 | 16 |
| 0.5 mcg/kg/min | 1 | 1 | 1 | 2 | 2 | 2 | 3 | 3 | 3 | 4 | 4 | 4 |
| Dose adjustment in **ml/hr** (*No max rate. For wt > 140kg, contact pharmacy if needed to calculate rate) | | | | | | | | | | | | |
| 0.5 mcg/kg/min | 1 | 1 | 1 | 2 | 2 | 2 | 3 | 3 | 3 | 4 | 4 | 4 |

**Converting to warfarin (Coumadin) after platelet count returns to above 100K:**

1. Argatroban can cause an elevation in INR beyond that seen with warfarin alone.
2. Argatroban to Warfarin Conversion:
   a. Start warfarin at a dose not to exceed 5 mg daily.
   b. Check INR daily.
   c. When INR > 4, hold Argatroban infusion and repeat INR in 6 hours.
   d. If repeat INR is in therapeutic range (2 – 4), discontinue Argatroban and continue warfarin monotherapy.
   e. If repeat INR is below therapeutic range, restart Argatroban at last infused rate and see (b) above.
3. Continue therapy with Argatroban **and** warfarin until the INR is in the desired range.

***Child-Pugh Score**

| Measure | +1 point | +2 points | +3 points |
|---|---|---|---|
| Bilirubin | < 2 | 2-3 | > 3 |
| Albumin | > 3.5 | 3.5-2.8 | < 2.8 |
| INR (no warfarin) | < 1.7 | 1.71-2.3 | > 2.3 |
| Ascites | None | Medically Controlled | Refractory |
| Hepatic Encephalopathy | None | Mild (I – II) | Severe (III-IV) |
| Total Score: | | | |

| Physician Signature | Date | Time | Nurse Signature | Date | Time |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ |

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## Argatroban Monitoring Flowsheet

Center Patient Admission Label Here

Make calculations based on a total body weight of _____Kg (round off to the nearest 10 Kg)

| PTT | RATE CHANGE | REPEAT PTT |
|---|---|---|
| Under 50 | Increase infusion by 0.5 mcg/kg/min (_____ml/hr) | STAT PTT in 2 hrs |
| 50-90 | No change (PTT is within goal range) | STAT PTT q 2hrs until PTT therapeutic X 2; then PTT q am |
| 91-150 | Decrease infusion by 0.5 mcg/kg/min (_____ml/hr) | STAT PTT in 2 hrs |
| Greater than 150 | HOLD Argatroban infusion, notify physician | Recheck PTT q 2hr until under 91 then decrease infusion by 0.5 mcg/kg/min and restart |

| DATE | TIME | PTT | INFUSION | | TIME HELD | NEXT PTT DUE | INR | RN SIGNATURE |
|---|---|---|---|---|---|---|---|---|
| | | | mcg/kg/min | ml/hr | | | | |
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