ArrIVe INFUSION THERAPY

An Outpatient Department of St. Mary's Hospital
2421 Malcom Bridge Rd Ste 820 Bogart, GA 30622-2325
Phone: 706-389-7802
Fax: 706-389-2501

Epoetin Alfa (Epogen®, Procrit®, Retacrit® or biosimilar)

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVe Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

Patient Name: _____ **Patient Address:** _____ **Patient Phone Number:** _____ **Date of Birth**: ____/____/____ **Weight:** _____kg **Height:** _____cm **Allergies:** _____	**Primary Insurance:** _____ **Member ID:** _____ **Secondary Insurance:** _____ **Member ID:** _____
Diagnosis Diagnosis Code (ICD-10): _____ Indication: _____ Target start date: _____ For patients with CKD not on dialysis, Epoetin alfa treatment may be initiated only when all the following apply: ▪ Scr greater than 3.0 or GFR below 60 ml/min ▪ Blood Pressure is less than 180/90 ▪ Hemoglobin level is less than 10 g/dL ▪ No deficiencies in B12, folate or Iron ▪ Erythropoietin level below 100	**Labs** Baseline: Prior to first treatment (within 45 days): Physician office to order initial lab work ☐ CBC, Creatinine serum, Iron, Ferritin, Transferrin, Folate, Vitamin B12, Erythropoietin Every 7 days: ☐ CBC Every 12 weeks: Pharmacist to place an order in Therapy Plan CBC ☐ Ferritin ☐ Transferrin Every 52 weeks: Pharmacist to place an order in Therapy Plan CBC ☐ Folate ☐ Vitamin B12 Other: _____ Target Hgb: 10-10.9 g/dL

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Epoetin Alfa (Epogen®, Procrit®, Retacrit® or biosimilar) Subcutaneous Injection

Initial dose:
For hemoglobin 8-9.9 g/dl, Epoetin alfa or biosimilar dose = 50 units/kg: Dose = _____ units subcutaneous ☐Weekly ☐Biweekly ☐Monthly for _____ months (max 12 months).
For hemoglobin below 8 g/dl, Epoetin alfa or biosimilar dose = 100/units/kg: Dose = _____ units subcutaneously ☐Weekly ☐Biweekly ☐Monthly for _____months (max 12 months)
OR Specify Initial dose: _____ units subcutaneously ☐Weekly ☐Biweekly ☐Monthly for _____ months (max 12 months)

Dose adjustments to be done by pharmacists for target hemoglobin of 10-10.9:
If hemoglobin does not increase by 1g/dL in 4 weeks and hemoglobin remains below 10 g/dL:
Increase dose by 25% *
Hemoglobin equal/above 11 g/dL:
Reduce dose by 25%*
Hemoglobin equal/above 11.6 g/dL:
Hold dose. Recheck CBC in 4 weeks. Resume epoetin alfa when hemoglobin below 10. If dose is on hold for 3 months in a row, notify physician office by phone and fax and discontinue algorithm with patient to return to physician office for monitoring.
If the hemoglobin rises more than 1 g/dL in any 2-week period: Reduce dose by 25%*
* Dose will be rounded to nearest vial size per EMR orderable

Do not increase the dose more frequently than once every 4 weeks.
A dose can be decreased more frequently than every 4 weeks.
If patient requires more than 90,000 units twice a month of epoetin alpha or biosimilar please notify physician office via fax

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Pre-Medications and Pre-Protocol (ordered at physician discretion)	☐ Acetaminophen 650 mg PO once ☐ Loratadine 10 mg PO once ☐ Diphenhydramine once ☐25 mg ☐50 mg ☐ PO ☐IV ☐ Famotidine 20 mg IV once ☐ Hydrocortisone 100 mg IV once ☐ Methylprednisolone 125 mg IVP once ☐ Other: _____	**Hydration** ☐ LR ☐ Sodium Chloride 0.9% ☐ Other _____ _____ mL at _____mL/hr ☐ Before ☐ During ☐ Following
Flushing Protocol *as needed for line care*	☐ **Sodium Chloride 0.9%** ☐ 5 mL ☐ 10 mL	☐ **Heparin 100 Units/mL** ☐ 5 mL ☐ 10 mL
Hypersensitivity Panel Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary	• **Sodium chloride** 0.9% bolus 500 mL once as needed for hypotensive management (SBP <90mmHg) • **Acetaminophen** 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping • **Albuterol** 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses • **Albuterol HFA** inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea • **Epinephrine** injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses • **Famotidine** injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • **Diphenhydramine** injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom • **Diphenhydramine** injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • **Hydrocortisone** sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure	

Provider Name: _____ Provider Signature: _____

Attending Physician Name: _____ Provider NPI: _____

Office Phone Number: _____ Office Fax Number: _____

Note: This order is valid for 12 months from date of physician signature.

SUBMIT