



ADULT AMBULATORY INFUSION ORDER

3/2023

Epoetin Alfa (Retacrit & Biosimilars) Maintenance for Anemia of CKD

NAME:
BIRTHDATE:
INSURANCE:
PROVIDER NAME:
CLINIC NAME and Phone number:

Patient identification

Weight: _____ kg Height: _____ cm Allergies: _____ Diagnosis Code: _____

Treatment Start Date: _____

****If treatment not started within 90 days, new orders with updated date/signature will be required. Otherwise, orders are valid for 1 year from signature date.****

- 1) Patient name and date of birth must be on EACH page of this order form. This form will be returned if any left blank.
- 2) Send FACE SHEET and complete copy of INSURANCE information. Send H&P or most recent chart note, must be within the past 12 months.
- 3) Send a copy of related lab results if not available for review in Epic.
- 4) Therapy with epoetin 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.

CKD stage: _____. ESRD-related (i.e., dialysis) indication; yes, or no? _____.

Required LABS:

- Hemoglobin & Hematocrit, STAT, every visit.
- Check here if okay to use POCT Hemoglobin if available at OPI location.

Optional labs below:

- CBC with differential, Routine, every _____ weeks.
- CMP, Routine, every _____ weeks.
- Ferritin, Routine, every _____ weeks.
- Iron and Iron Binding Capacity Routine, every _____ weeks.
- Other: _____ Routine, every _____ weeks.

MEDICATION:

- Epoetin Alfa.** Patient will be given biosimilar substitute (Epogen, Procrit, Retacrit) according to insurance coverage/preference. If insurance coverage allows, patient will receive drug based on pharmacy availability and the Providence Preferred Products List.
- Only check this box if it is NOT okay to substitute for insurance/Providence preferred product. Specific product required: _____, **specific reason why this is required:** _____.

Dose & Interval:

- _____ units, SQ injection, every _____ weeks. *Hold injection if Hgb 11 or higher.*

Standard included Nursing Orders:

- Vitals on admission.
- Hgb must be less than 10 g/dL to initiate treatment (drawn within one week of initial dose). If a patient has signs and symptoms of illness, fever or malaise hold an injection and notify physician. Hold if systolic BP is greater than 160 mmHg and notify physician.
- Hold injection if Hgb 11 or higher.

HYPERSENSITIVITY INJECTION REACTION ORDERS

MILD REACTION: Localized pruritus, rhinitis, localized rash, fever greater than 38 degrees C.

1. Notify MD of symptoms and hypersensitivity reaction orders initiated.



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MODERATE REACTION: Generalized pruritus, generalized flushing, rash, back pain, mild dyspnea, chills, hypotension with SBP less than 90 mmHg or greater than 20% decrease in SBP.

1. Start IV and maintain IV access with NS line per provider instruction.
2. Place patients in a supine position with lower extremities elevated unless respiratory distress or nausea/vomiting.
3. Maintain airway.

SEVERE REACTION: Respiratory distress (bronchospasm, stridor, wheezing, persistent cough, respiratory depression, cardiac arrhythmia, chest pain, generalized urticaria (hives), syncope, gastrointestinal symptoms (abdominal pain, N/V, diarrhea), hypotension SBP less than 80 mmHg, face/throat/tongue swelling, shock, loss of consciousness.

1. Start IV and maintain IV access with NS line per provider instruction.
2. Stay with patient and have another nurse notify MD of symptoms and infusion reaction orders initiated.
3. Place patients in supine position with lower extremities elevated unless respiratory distress or nausea/vomiting.
4. Maintain airway.

MEDICATIONS:

- Acetaminophen (TYLENOL) tablet 650 mg, Oral, EVERY 4 HOURS PRN, Mild or moderate reaction. Starting when released, for 2 doses.
- Diphenhydramine (Benadryl) capsule, 25mg, PO, prn. Mild hypersensitivity reaction. May repeat x1.
- Diphenhydramine (Benadryl) injection, 25 mg, Intravenous, EVERY 15 MIN PRN, Moderate or severe reaction, may repeat x1. Starting when released, For 2 doses.
- Prednisone (Deltasone) tablet, 40mg, PO. Once, for Mild hypersensitivity reaction.
- Methylprednisolone sodium succinate (solu-MEDROL) 62.5mg/ml injection, 125 mg, Intravenous, ONCE PRN, moderate or severe reaction. Starting when released, For 1 dose. Mix with 2 mL provided diluent to make 62.5 mg/mL.
- Famotidine (Pepcid) tablet, 20mg, PO. Once, for Mild hypersensitivity reaction.
- Famotidine (Pepcid) injection 20 mg, Intravenous, ONCE PRN, Moderate or severe reaction, for 1 dose. Dilute 2 mL of famotidine with 8 mL of normal saline to a final concentration of 2 mg/mL. Administer ordered dose over a period of at least 2 minutes.
- Albuterol 90 mcg/puff inhaler 2 puff, Inhalation, ONCE PRN, Shortness of breath, severe reaction. Starting when released, For 1 dose. Shake well. Use with spacer.
- Start oxygen. For *MODERATE* Reaction: Start 2 liters O2 per nasal cannula as needed for SpO2 less than 93%. For *SEVERE* Reaction: Start continuous pulse oximetry. Administer 6 to 8 liters per minute (LPM) via face mask, or up to 100% oxygen to maintain oxygen saturation greater than 90%.
- EPINEPHRINE 1 mg/mL injection 0.3 mg. Intramuscular, EVERY 5 MIN PRN, Anaphylaxis. Starting when released, For 3 doses. Administer in the anterior lateral thigh using 1 - 1.5-inch needle for airway obstruction symptoms and/or hypotension.
- Sodium chloride 0.9% (NS) infusion 500ml. At 500 mL/hr., Intravenous, PRN, Moderate reaction, or anaphylaxis. Starting when released. Run wide open to gravity.



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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.

My physician license Number is # _____ and I am acting within my scope of practice and authorized by law to order infusion of the medications and blood products described above for the patient identified on this form.

Provider's printed name: _____

Provider's signature: _____

Date: _____

Please complete the following intake questions.

Mobility status

- Independent
- Walker
- Wheelchair
- Fully dependent

Bariatric needs

- Yes, briefly describe _____
- No

Transportation concerns

- Yes, briefly describe _____
- No

Interpreter Service required

- Yes, language _____
- No

Outpatient Infusion Services Intake Team:

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

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> PORTLAND | Phone-503-215-6046 Fax-503-487-3582 |
| <input type="checkbox"/> WILLAMETTE FALLS | Phone-503-215-6046 Fax-503-487-3582 |
| <input type="checkbox"/> MEDFORD | Phone-541-732-7000 Fax-541-732-3939 |
| <input type="checkbox"/> HOOD RIVER | Phone-541-387-6445 Call for fax # |
| <input type="checkbox"/> SEASIDE | Phone-503-717-7650 Fax-503-470-3146 |
| <input type="checkbox"/> NEWBERG | Phone-503-537-6040 Fax-503-205-8720 |