MUNSON HEALTHCARE

10499

ADULT CKD - EPOETIN/IRON ORDERS

AUTHORIZATION IS GRANTED TO DISPENSE AND ADMINISTER AN ALTERNATE DRUG PRODUCT ACCEPTABLE TO THE MEDICAL STAFF'S PHARMACY COMMITTEE UNLESS THE DRUG PRODUCT IS SPECIFICALLY CIRCLED.

DIAGNOSIS (required):	**ICD-10 CODE (required):**	**Is patient receiving chemotherapy?** ☐ **Yes** ☐ **No**
☐ **Anemia in CKD, non-dialysis** (If patient is on dialysis, different form must be used.) ☐ **Other:**		**Order Expiration Date (required):**

Allergies/reactions:

LABS: (Provider to enter separate lab order for all tests)

Baseline: Hemoglobin/hematocrit, TIBC, TSAT, Ferritin ONCE *(Hgb must be less than 10 g/dL to initiate therapy)*

Maintenance:
Epoetin only: Hemoglobin/hematocrit prior to each dose *(state frequency on lab order)*
Iron Replacement: TIBC, TSAT, Ferritin every 3 months

ORDERS:

Current Weight: _____kg

Epoetin-Alfa-epbx (Retacrit): _____**units subcutaneously** ☐ **weekly** ☐ **every other week** ☐ **every 3 weeks** ☐ **monthly**

DOSE ADJUSTMENTS PER PHARMACY		**Date**	**Date**	**Date**	**Date**
	Hemoglobin				
	New Dose *(round per pharmacy)*				

☐ Check if iron replacement is desired *(based on maintenance labs ordered)*.

Iron Sucrose (Venofer) IV Dosing Protocol:

- *Target serum ferritin at least 100 ng/mL, TSAT at least 20%*
- *Hold Iron Sucrose dose if ferritin > 700 ng/mL*

TSAT%	Iron Sucrose Dosing
> 20%	NO IRON
18-20%	200 mg IV weekly x 2 doses
15 - 17%	200 mg IV weekly x 3 doses
≤ 14%	200 mg IV weekly x 4 doses

Epoetin-Alfa-epbx (Retacrit) Dosing Protocol *(adjust epoetin therapy as follows):*

- If hemoglobin is greater than or equal to 10.6 g/dL:
  - ***HOLD*** *epoetin dose.*
  - *Recheck hemoglobin/hematocrit at the next scheduled appointment.*
  - *When hemoglobin is less than 10.6 g/dL, restart epoetin with a 25% dose reduction from the last dose administered.*
  - *Indicate dose adjustment above.*
- If hemoglobin increases by greater than 1 g/dL in any 2-calendar week period:
  - *Continue with epoetin dose with a 25% dose reduction from the last dose administered.*
  - *Indicate dose adjustment above.*
- After any 4-calendar weeks of therapy, if hemoglobin remains less than 9.5 g/dL **AND** the hemoglobin has not increased by at least 1 g/dL from baseline **AND** TSAT > 20 %:
  - *Increase dose by 25% (using the last dose administered).*
  - *Inform ordering provider of the dose increase.*
  - *Indicate dose adjustment.*

_____
PATIENT NAME

_____
DATE OF BIRTH

THE PROVIDER'S FULL SIGNATURE, DATE & TIME IS TO FOLLOW THE ORDER - ABBREVIATIONS FOR NAMES ARE NOT ACCEPTABLE.

_____
PROVIDER PRINTED NAME

_____ _____ _____
PROVIDER SIGNATURE DATE TIME