LOWER UMPQUA HOSPITAL
OUTPATIENT NURSING DEPARTMENT
600 Ranch Road, Reedsport, OR 97467
Phone: (541) 271-2163 | **Fax:** (541) 271-4058

EPOETIN ALFA AND BIOSIMILARS

Patient Name _____ **DOB** _____

Patient Phone # _____ **Patient Weight (Kg)** _____ **Patient Height (cm):** _____

Patient Allergies _____

Provider _____ **NPI#** _____

ICD-10 Code (REQUIRED) _____ **J Code** _____

Primary Diagnosis _____

Secondary Diagnosis _____

Duration (or # of treatments): _____ **Anticipated Infusion Date** _____

INSTRUCTIONS TO PROVIDER:

- *This treatment plan will expire **after 365 days**, at which time new orders will need to be placed.*

MEDICATIONS:

☒ **epoetin alfa-ebx** *(RETACRIT)* injection, subcutaneous
Indication: _____
Dosing & Interval:

- ☐ **10,000 units every week**; then Pharmacist to use DOSING INSTRUCTIONS in the "Ordering Guidelines" for further dosing
  Other: _____ **units, every** _____ **weeks**; then Pharmacist to use DOSING INSTRUCTIONS in the **Ordering Guidelines** for further dosing
- ☐ **Continue most recent dosing and** Pharmacist to use DOSING INSTRUCTIONS in the **Ordering Guidelines** for further dosing
- ☐ **Fixed Dosing**: _____ **units, every** _____ **weeks**. Specify hold parameters or other instructions. _____

_____

_____

ORDERING GUIDELINES:

- ☒ Send **FACE SHEET and H&P or most recent chart note**
- ☒ **epoetin alfa-epbx** *(RETACRIT)* is the only epoetin alfa product (a biosimilar to Epogen and Procrit) available for adult patients at LUH. The dose will be rounded to the nearest 1000 units and to the nearest vial size (within +/- 10%). In cases of a drug shortage, the pharmacist may substitute another brand of epoetin alfa.
- ☒ Evaluate iron status (transferrin, ferritin, TIBC) before and during treatment (every 3 months). Supplemental iron should be prescribed if serum ferritin is **less than** 100 ng/mL or TSAT is **less than** 20%. Providers must also assess and replete folate and Vitamin B12 prior to any treatment with epoetin alfa.
- ☒ Supplemental courses of iron should be completed BEFORE initiation of the epoetin alfa and should be maintained throughout therapy.
- ☒ If supplemental iron is needed while the patient is already on epoetin alfa therapy, the therapy may continue only if hemoglobin meets the prescribed treatment parameters.

Continued on next page ➔

Date _____ Time _____ Provider Signature _____

"Statement of Responsibility of Parties: referring Prescriber agrees that in referring patients to Lower Umpqua Hospital Outpatient Nursing Department, the responsibility for the care related to these Outpatient Nursing Therapy Plan orders, as well as administration of any 340B drugs, remains with Lower Umpqua Hospital."

Patient Label

LOWER UMPQUA HOSPITAL
OUTPATIENT NURSING DEPARTMENT
600 Ranch Road, Reedsport, OR 97467
Phone: (541) 271-2163 | **Fax:** (541) 271-4058

EPOETIN ALFA AND BIOSIMILARS

Patient Name _____ **DOB** _____

ORDERING GUIDELINES, continued**:**

☒ Hemoglobin and hematocrit must be obtained **within 1 week prior to therapy initiation**. Hemoglobin must be **less than** 10 g/dL or hematocrit must be **less than** 30% prior to initiation.

DOSING INSTRUCTIONS for CKD patients NOT on dialysis (for other indications, order indication-specific dosing):

- **Hemoglobin (HGB) target = 10 to 11.5 g/dL *OR* another target, specify:** _____
- **INITIAL:** Weekly dosing and HGB lab testing Q2 weeks, until target met for 2 consecutive values, then may decrease HGB lab testing to once Q4 weeks
- If HGB increase is ***greater than*** 1 g/dL in any 2-week period (or ***greater than*** 2 g/dL in any 4-week period), DECREASE dose by ***greater than/equal to*** 25% to 50% (unless met parameters to hold)
- If HGB does NOT increase by ***greater than*** 1 g/dL or shows no increase after 4 weeks (AND HGB is below goal), INCREASE dose by 25% (do not increase more than once Q4 weeks)
- If HGB drops by 1 g/dL or more (AND HGB is below target), INCREASE dose by 25%
- If HGB is increasing and approaching the upper target threshold, may DECREASE dose by 25%.
- **HOLD DOSE if HGB is above target** and repeat CBC Q2 weeks until HGB at goal. NOTIFY PROVIDER if remains ABOVE target **x** 2. After HGB returns to the target range, restart at 25% lower dose
- **Maintain current dosing** when HGB is at target. Use lowest maintenance dose necessary to reduce the need for transfusions and manage symptoms.

LABS:

☒ Hemoglobin & Hematocrit, once, every visit.
See **Ordering Guidelines for instructions regarding further lab monitoring.*

☒ Iron studies (transferrin and TIBC) and ferritin, once, every 3 months

☐ CMP, ONCE

☐ Vitamin B 12, ONCE

☐ Folate (serum), ONCE

TREATMENT PARAMETERS:

☒ NOTIFY PROVIDER if:

- HGB **less than** 10 g/dL despite therapy and dose increases over a 12-week period
- HGB drops **less than** 2 g/dL
- If no HGB response by 12 weeks ***or*** have not met target despite high doses of over 450 units/Kg per week, in the presence of adequate iron stores, contact Provider to reassess for other underlying causes
- HOLD treatment and notify provider if
  - Systolic blood pressure (SBP) **greater than** 180 mmHg, or
  - Diastolic blood pressure (DBP) **greater than** 100 mmHg.
- HOLD treatment and notify Provider if serum ferritin is **less than** 100 ng/mL and TSAT is **less than** 20%
  - May resume epoetin treatment after a new course of iron therapy is initiated

Continued on next page ➔

Date _____ Time _____ Provider Signature _____

"Statement of Responsibility of Parties: referring Prescriber agrees that in referring patients to Lower Umpqua Hospital Outpatient Nursing Department, the responsibility for the care related to these Outpatient Nursing Therapy Plan orders, as well as administration of any 340B drugs, remains with Lower Umpqua Hospital."

Patient Label

LOWER UMPQUA HOSPITAL
OUTPATIENT NURSING DEPARTMENT
600 Ranch Road, Reedsport, OR 97467
Phone: (541) 271-2163 | **Fax:** (541) 271-4058

EPOETIN ALFA AND BIOSIMILARS

Patient Name _____ **DOB** _____

LINE CARE MAINTENANCE: LINE CARE MAINTENANCE:

- ☒ Follow facility policies/procedures for all vascular access maintenance with appropriate flush solutions, de-clotting (**alteplase**), and/or dressing changes
- ☒ **alteplase** *(CATHFLO ACTIVASE)* injection 2 mg/2 mL intra-catheter **x** 1 PRN de-clotting **x** 2 doses
- ☒ **heparin, porcine - Preservative Free (PF)** 100 units/mL IV syringe 500 units intra-catheter **x** 1 PRN line care
- ☒ **0.9% sodium chloride** 10 mL IV flush PRN as needed
- ☒ If applicable, may remove PICC line at the completion of course of therapy

EMERGENCY MEDICATIONS FOR HYPERSENSITIVITY / INFUSION REACTION:

** *Itching, hives, fever* **

- ☒ **STOP MEDICATION INFUSION if allergic reaction occurs**
- ☒ Establish IV access and infuse **0.9% sodium chloride** 500 mL at 25 mL/hour PRN Hypersensitivity / Allergic reaction
- ☒ VS Q15 minutes **x** 4 and PRN
- ☒ **acetaminophen** *(TYLENOL)* 650 mg PO Q4HRS PRN Hypersensitivity / Allergic Reaction.
- ☒ **diphenhydramine** *(BENADRYL)* 25 MG IVP PRN Hypersensitivity / Allergic Reaction **x** 1 dose. May repeat **x** 1 ***{Maximum dose = 50 mg}***
- ☒ **NOTIFY** Provider of Hypersensitivity / Allergic Reaction
- ☒ **hydrocortisone** 100 mg IVP PRN Hypersensitivity / Allergic Reactions **x** 1 dose if reaction continues and is not relieved by maximum dose of **diphenhydramine**

ANAPHYLAXIS REACTION

** *Wheezing, Dyspnea, Hypotension, Angioedema, Chest pain, Tongue swelling* **

- ☒ Transfer to Emergency Department (ED) as needed, and **NOTIFY** Provider
- ☒ **epinephrine** 0.3 mg IM PRN anaphylaxis **x** 1 dose

Date _____ Time _____ Provider Signature _____

"Statement of Responsibility of Parties: referring Prescriber agrees that in referring patients to Lower Umpqua Hospital Outpatient Nursing Department, the responsibility for the care related to these Outpatient Nursing Therapy Plan orders, as well as administration of any 340B drugs, remains with Lower Umpqua Hospital."

Patient Label