



**LOWER UMPQUA HOSPITAL
OUTPATIENT NURSING DEPARTMENT
600 Ranch Road, Reedsport, OR 97467**

For Referrals: (541) 271-2163 – Press #3 (all other services) then press # 2 (Referrals)

For Outpatient Nursing: (541) 271-2171 ext. 5205

FAX: (541) 271-5433

EPOETIN ALFA-EBX (RETACRIT) 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 panel and Ferritin 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.

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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."

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Patient Name _____ DOB _____

ORDERING GUIDELINES, continued

- ☒ 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.
- ☒ 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 per dosing instructions.
*See **Ordering Guidelines** for instructions regarding further lab monitoring.
- ☒ Iron panel 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

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EPOETIN ALFA-EBX (RETACRIT) AND BIOSIMILARS

Patient Name _____ **DOB** _____

TREATMENT PARAMETERS, continued

- 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

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

***REFERENCES:**

1. PROCRIT (epoetin alfa) [prescribing information]. Horsham, PA: Janssen; July 2018.
2. RETACRIT (epoetin alfa-epbx) [prescribing information]. Lake Forest, IL: Hospira Inc; May 2023.
3. KDIGO clinical practice guideline for anemia in chronic kidney disease. *Kidney Int Suppl.* 2012; 2(suppl):279-335.

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