

Columbus Community Hospital

Columbus, Nebraska

**DOCTORS ORDERS**

PLEASE NOTE: Condition of Wound, Removal of Stitches, Consultation, Change in Diagnosis, Complications, Condition on Discharge, Instructions of Patient.

**PLEASE SIGN AND DATE EACH ENTRY**

**PLEASE INDICATE / ALLERGIES**

NONE	CODEINE	PENICILLIN	SULFA	ASPIRIN	OTHER	HEIGHT
REACTION						WEIGHT

Authorization is granted to supply medications by non-proprietary name unless checked here

**PHYSICIANS ORDERS  
(including Medications)**

**Epoetin Alfa-epbx (RETACRIT) Injection**

**(8/2024)**

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Diagnosis Code: \_\_\_\_\_

Treatment Start Date: \_\_\_\_\_ Patient to follow up with provider on date: \_\_\_\_\_

**\*\*This plan will expire after 365 days at which time a new order will need to be placed\*\***

**GUIDELINES FOR ORDERING**

1. **Send FACE SHEET and H&P or most recent chart note detailing treatment indication and plan.**
2. Hemoglobin and hematocrit must be obtained within 1 week of therapy initiation. Hemoglobin must be less than 10 g/dL or hematocrit must be < 30% prior to initiation.
3. Serum ferritin and transferrin saturation (TSAT) must be performed every 3 months during erythropoiesis stimulating agent (ESA) treatment (serum ferritin ≥ 100 ng/mL, and TSAT ≥ 20%). Therapy with ESA may continue only if hemoglobin meets maintenance treatment parameters per indication.
4. All patients must be negative when evaluated for blood loss, hemolysis, and bone marrow fibrosis prior to initiation of therapy. Providers must assess and replete iron, folate, and Vitamin B12 prior to any treatment with ESA.
5. Patients cannot receive Iron Sucrose (VENOFER) and/or Vitamin B12 on the same day as ESA treatment. Patients may be on prophylactic oral iron supplementation concurrent with ESA treatment as long as supplementation for the prevention of iron deficiency is necessary due to ESA therapy alone.

**LABS:**

- Hemoglobin & Hematocrit, Routine, ONCE, every \_\_\_\_\_ (visit)(days)(weeks)(months) – CHOSE ONE
- Ferritin, once clinic collect, comment as needed if not resulted in last 90 days, interval quarterly
- Iron and TIBC, once clinic collect, comment as needed if not resulted in last 90 days, interval quarterly
- Labs already drawn. Date: \_\_\_\_\_ (Labs scanned with orders).

**NURSING ORDERS:**

1. Patients cannot receive Iron Sucrose (VENOFER) and/or Vitamin B12 on same day as ESA treatment.
2. Do not obtain ferritin or transferrin saturation (TSAT) on the same day as ESA treatment.
3. OK to give erythropoiesis-stimulating agents on the same day as blood transfusions.
4. TREATMENT PARAMETERS –
  - a. Hemoglobin and hematocrit must be obtained within 1 week of each individual ESA treatment.
  - b. Hemoglobin must be less than 10 g/dL or hematocrit must be less than 30% prior to initiation.
  - c. Hold treatment and call provider if lab parameters are not met or if blood pressure is greater than 180 mm Hg systolic or 100 mm Hg diastolic

**Monitoring Parameters:**

- Hold dose and contact physician if Hgb ≥ \_\_\_\_\_g/dL.

**(cont.)**



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**Page 2 of 3**

**MEDICATIONS:**

- **Epoetin alfa-epbx (RETACRIT), subcutaneous, ONCE**  
Initiate first dose within 1 week of obtaining baseline labs.

**Fixed dose regimens: (must check one)**

- 2,000 units
- 3,000 units
- 4,000 units
- 10,000 units
- 20,000 units
- 40,000 units

**Interval:**

- Once
- Weekly x \_\_\_\_\_ weeks
- \_\_\_\_\_ times per week x \_\_\_\_\_ week

**HYPERSENSITIVITY:**

1. NURSING COMMUNICATION – If hypersensitivity reactions develop, refer to **Adult Hypersensitivity (HSR) & Allergic Reaction Management** algorithm for assessment guidelines and interventions.
2. Obtain vital signs and continue to monitor vitals every 5 minutes.
3. Notify ordering provider.
4. Continue to assess as grade of severity may progress.
5. Administer emergency medications as directed on the physician's orders.

**HYPERSENSITIVITY MEDICATIONS:**

- **Acetaminophen, 975 mg, PO, x 1 dose, AS NEEDED** for hypersensitivity or infusion reaction.
- **DiphenhydrAMINE inj, 50 mg, IV, AS NEEDED** for hypersensitivity or infusion reaction. May repeat x 1 AS NEEDED per reaction management algorithm.
- **Hydrocortisone Sodium Succinate, 100 mg, IV, AS NEEDED x 1 dose** for hypersensitivity or infusion reaction.
- **Famotidine, 20 mg, IV, AS NEEDED x 1 dose** for hypersensitivity or infusion reaction.
- **Oxygen, 2 Liters/min** per nasal cannula for hypersensitivity or infusion reaction.
- **0.9% Normal Saline, 1000 mL, IV, 150mL/hr, AS NEEDED** for hypersensitivity or infusion reaction.
- **EPINEPHrine HCl (1mg/1mL), 0.3 mg, IM injection, AS NEEDED x 1 dose** for hypersensitivity or infusion reaction.

My NPI number is \_\_\_\_\_ **(MUST BE COMPLETED TO BE A VALID PRESCRIPTION)**; and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

(cont.)



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Provider signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_