**ERYTHROPOIESIS STIMULATING AGENTS (ESAs) ORDER FORM**

**ARANESP® (darbepoetin alfa), Epogen® / Procrit® (epoetin alfa)**

<table>
<thead>
<tr>
<th>Patient Weight</th>
<th>Kilograms</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Baseline Hemoglobin / Hematocrit on Day 1 if not available.</td>
<td>□ Serum Ferritin / Iron / TIBC Q________</td>
</tr>
<tr>
<td>□ Hemoglobin / Hematocrit Q________</td>
<td>□ Folate Level Q________</td>
</tr>
<tr>
<td>□ CBC w/ DIFF Q________</td>
<td>□ B-12 Level Q________</td>
</tr>
</tbody>
</table>

**Non-Oncology ESA Indications**

- Patients receiving ESA therapy for non-oncology indications are not required to be registered in the ESA APPRISE ONCOLOGY Program, however must receive an Aranesp Medication Guide monthly.
- Patients receiving dialysis will receive the first dose of Aranesp with the second scheduled dialysis session.
- Receiving Dialysis: Hold if Hgb level exceeds 11g/dL.
- Not On Dialysis: Hold for Hgb level greater than 10g/dL.

**DX: Anemia in Chronic Kidney Disease**

- Currently receiving Dialysis? □ YES □ NO
- □ Darbepoetin □ 25 □ 40 □ 60 micrograms □ SQ □ IV
  - Q__ Week(s) Begin on _________(date) X _____months

**DX: Anemia in Chronic Kidney Disease (Dose > 60 mcg)**

- □ Darbepoetin □ ______ micrograms □ SQ □ IV
  - Q__ Week(s) Begin on _________(date) X _____months

**DX: Reduction of Allogeneic Blood Transfusion in Surgery**

- Patients: Epoetin alfa is indicated for the treatment of anemic patients (hemoglobin levels greater than 10 grams/deciliter (g/dL) up to 13 g/dL) who are high risk for perioperative blood loss from elective, noncardiac, nonvascular surgery to reduce the need for allogeneic blood transfusions.
  - □ Epoetin 300 Units / Kg  SQ Daily for 10 days before surgery, the day of surgery, and 4 days after. Begin on __________(date)
  - or
  - □ Epoetin 600 Units / Kg  SQ Weekly at 21, 14, and 7 days prior to surgery with the 4th dose on the day of surgery. Begin on __________(date)

**DX: Anemia of Critical Illness**

- □ Epoetin 40,000 Units SQ
  - □ Darbepoetin ______ micrograms SQ
  - Q______ Week(s) Begin on __________(date)
  - □ One Time Dose  Administer: _____________(date)
  - □ Darbepoetin ______ micrograms SQ
  - Q______ Week(s) Begin on ___________(date) X _____months

- □ One Time Dose  Administer: _____________(date)

**APPRIZE Program Required Information**

As required by the FDA Risk Evaluation and Mitigation Strategy (REMS) program for ESAs, all orders for use in oncology patients are subject to audit and monitoring by the Assisting Providers and Cancer Patients with Risk information for the Safe use of ESAs (APPRIZE) Oncology Program. This order set is required in order to ensure that Roper St. Francis meets the requirements for compliance with the APPRIZE program. **Failure to comply with the ESA APPRISE Oncology Program requirements will result in suspension of access by the hospital to ESAs. Therapy will not be dispensed unless all required information is supplied.**

- □ This is a New Patient (1 and 2 required for dispensing)
- □ Existing Patient (HCP Acknowledgement Form has previously been submitted for this course of therapy)

1. □ I am enrolled in the ESA APPRISE Program. Dose will be dispensed upon confirmation by a pharmacist.
2. □ The Patient / Physician Acknowledgement Form must be completed and scanned to the Pharmacy Department along with this completed order form.

- The signed form is in the patients hospital chart in the MD orders section. Please scan to pharmacy along with this form.
- The signed form is on file in the physician’s office. Please contact the office at ___________ and have the form sent to:
  - Roper Hospital Pharmacy fax # 843-724-2282
  - Roper Berkeley Pharmacy fax # 843-724-2282
  - St. Francis Hospital Pharmacy fax # 843-402-1289
  - Mt. Pleasant Hospital Pharmacy fax # 843-606-7917

**DX: Chemotherapy Induced Anemia**

- Hold if Hgb level is greater than 10g/dL.
  - **Outpatient Infusion Only**: Contact ordering physician prior to the patient’s 4th dose for re-assessment if patient meets any of the following criteria:
    - Hgb level increase of less than 1g/dL
    - Greater than 4 weeks post last cycle of chemotherapy
    - Hgb level greater than 11g/dL
    - Patient has been placed in Hospice care

- □ Darbepoetin ______ micrograms SQ
  - Q______ Week(s) Begin on __________(date) X _____months

- □ One Time Dose  Administer: _____________(date)

- Provide a Medication Guide to patients for all indications. (Must be signed before sending to Pharmacy)

I have provided a medication guide to the patient prior to administration of the dose. Signature: __________________________

MD Signature_________________________ Date / Time __________________________

Original Feb 2011, Rev. 8/11; 7/14, 9/14a; 11/14; 8/15