Corewell Health™

Patient Name	
DOB	
MRN	
Physician	
CSN	

Physician's Orders
EPOETIN ALFA (PROCRIT/RETACRIT) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER

Corewell Health Site of Service (select one):

☐ **Blodgett Hospital**
1840 Wealthy St. SE
Grand Rapids, MI 49506
Phone: 616.391.0351
Fax: 616.391.8969

☐ **Gerber Hospital**
230 West Oak St.
Fremont, MI 49412
Phone: 231.924.1305
Fax: 231.924.1798

☐ **Greenville Hospital**
615 S. Bower St.
Greenville, MI 48838
Phone: 616.225.9330
Fax: 616.754.4043

☐ **Helen DeVos Children's Hospital**
35 Michigan St. NE Floor 2
Grand Rapids, MI 49503
Phone: 616.267.1925
Fax: 616.267.1005

☐ **Lemmen Holton Cancer Pavilion**
145 Michigan St. NE Ste 5200
Grand Rapids, MI 49503
Phone: 616.486.6099
Fax: 616.486.6415

☐ **Ludington Hospital**
1 Atkinson Dr.
Ludington, MI 49431
Phone: 231.845.5085
Fax: 231.845.5025

☐ **Neuro Infusion ICCB**
2750 E Beltline Ave. NE
Grand Rapids, MI 49525
Phone: 616.391.0351
Fax: 616.391.8969

☐ **Pennock Hospital**
1009 W Green St.
Hastings, MI 49058
Phone: 269.798.6762
Fax: 269.798.6763

☐ **Reed City Hospital**
4499 S 220th Ave.
Reed City, MI 49677
Phone: 231.832.7105
Fax: 231.832.0195

☐ **Zeeland Hospital**
8333 Felch St.
Zeeland, MI 49464
Phone: 616.748.3640
Fax: 616.748.3690

☐ **Brownstown Infusion Clinic**
19725 Allen Rd. Ste 101
Brownstown Twp, MI 48183
Phone: 734.479.2371
Fax: 734.479.2451

☐ **Dearborn Hospital**
18101 Oakwood Blvd.
Dearborn, MI 48124
Phone: 313.593.5913
Fax: 313.593.8551

☐ **Farmington Hills Hospital Botsford**
28050 Grand River Ave.
Farmington Hills, MI 48336
Phone: 947.521.8174
Fax: 248.471.8217

☐ **Grosse Pointe Infusion Clinic**
21400 E 11 Mile Rd.
Saint Clair Shores, MI 48081
Phone: 586.498.4498
Fax: 586.498.4497

☐ **Lenox Infusion Clinic**
36555 26 Mile Rd. Ste 3300
Lenox, MI 48048
Phone: 947.523.4060
Fax: 947.523.4061

☐ **Livonia Infusion Clinic**
39000 W 7 Mile Rd. Ste 3000
Livonia, MI 48152
Phone: 947.523.4360
Fax: 734.542.3356

☐ **Royal Oak**
3601 W 13 Mile Rd.
Royal Oak, MI 48073
Phone: 248.898.1000
Fax: 248.551.3168

☐ **Troy Hospital**
44344 Dequindre Rd. Ste 230
Sterling Heights, MI 48314
Phone: 248.964.3080
Fax: 248.964.2409

☐ **Wayne Hospital**
33155 Annapolis St.
Wayne, MI 48184
Phone: 734.467.2556
Fax: 734.467.2505

☐ **Marie Yeager Cancer Center**
3900 Hollywood Rd.
Saint Joseph, MI 49085
Phone: 269.556.7180
Fax: 269.556.7185

☐ **Niles Infusion**
42 N St. Joseph Ave. Ste 303
Niles, MI 49120
Phone: 269.684.6140
Fax: 269.683.8744

☐ **Watervliet Hospital**
400 Medical Park Dr.
Watervliet, MI 49098
Phone: 269.463.2310
Fax: 269.463.0012

PATIENT INFORMATION:

Name: First _____ Middle _____ Last _____

Date of birth _____ Phone (_____) _____

Address _____

City _____ State _____ Zip code _____

REFERRAL: Infusion Therapy

Referring Physician (print) _____

Office: Phone (_____) _____ Fax (_____) _____

Direct line for urgent questions about patient (_____) _____

CONTINUED ON PAGE 2 ➔

NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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EPOETIN ALFA (PROCRIT/RETACRIT) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER *(CONTINUED)*

Infusions:

Anticipated Infusion Date: _____ **ICD-10 Code with Description:** _____

Height _____ (cm) Weight _____ (kg) Allergies _____

Labs to be collected:

☒ Hemoglobin + Hematocrit (H+H)
- ☐ Once
- ☒ Every Visit
- ☐ _____

☒ Transferrin, Blood Level
- ☒ Once
- ☐ Every Visit
- ☐ _____

☒ Ferritin, Blood Level
- ☒ Once
- ☐ Every Visit
- ☐ _____

☒ Iron and Iron Binding Capacity Level
- ☒ Once
- ☐ Every Visit
- ☐ _____

☒ Erythropoietin
- ☒ Once
- ☐ Every Visit
- ☐ _____

☒ Reticulocyte Count with Reticulocyte Hemoglobin
- ☒ Once
- ☐ Every Visit
- ☐ _____

☐ Additional lab order(s) _____
- ☐ Once
- ☐ Every visit
- ☐ _____

Treatment:

Frequency:
- ☐ Once
- ☐ Every 7 days
- ☐ Every 14 days
- ☐ Every _____ days

Duration:
- ☐ # of treatments _____
- ☐ Until date: _____
- ☐ 1 year

☐ **Epoetin alfa-epbx (RETACRIT)**, Subcutaneous
- ☐ 40,000 units
- ☐ 60,000 units
- ☐ 50 units/kg
- ☐ 100 units/kg
- ☐ _____ units OR units/kg

☐ **Epoetin alfa (EPOGEN, PROCRIT)**, Subcutaneous
- ☐ 40,000 units
- ☐ 60,000 units
- ☐ 50 units/kg
- ☐ 100 units/kg
- ☐ _____ units OR units/kg

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EPOETIN ALFA (PROCRIT/RETACRIT) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER *(CONTINUED)*

Supplemental Orders

*****The following orders will be applied to the patient's plan unless otherwise indicated*****

Appointment Requests

☒ **Infusion Appointment Request**

Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after infusion and possible labs.

Provider Ordering Guidelines

☒ **ONC PROVIDER REMINDER 10**

EPOETIN ALFA or EPOETIN ALFA-EPBX ORDERING GUIDELINES:

Retacrit (epoetin alfa-epbx) is approved as a biosimilar to Epogen (epoetin alfa) and Procrit (epoetin alfa). Epoetin alfa-epbx (RETACRIT) Is the preferred formulation at Corewell Health.
Doses are usually rounded to the nearest vial size.

Evaluate iron status in all patients before and during treatment and maintain iron repletion.

In patients with ANEMIA due to CHRONIC KIDNEY DISEASE (CKD), individualize dosing and use the lowest dose necessary to reduce the need for RBC transfusions.
Do not increase dose more frequently than every 4 weeks (dose decreases may occur more frequently); avoid frequent dosage adjustments. Most patients with chronic kidney disease (CKD) will require iron supplementation.

If Hb does not increase by GREATER THAN 1 g/dL after 4 weeks: Increase dose by 25%.

If Hb increases GREATER THAN 1 g/dL in any 2-week period: Reduce dose by GREATER THAN OR EQUAL TO 25%.

Inadequate or lack of response over a 12-week escalation period: Further increases are unlikely to improve response and may increase risks; use the minimum effective dose that will maintain a Hb level sufficient to avoid RBC transfusions and evaluate patient for other causes of anemia. Discontinue therapy if responsiveness does not improve.

In patients with ANEMIA due to CHEMOTHERAPY IN CANCER PATIENTS, discontinue erythropoietin following completion of chemotherapy.

If hemoglobin does not increase by GREATER THAN OR EQUAL TO 1 g/dL and remains less than 10 g/dL after initial 4 weeks: Increase to 900 units/kg (maximum dose: 60,000 units); discontinue after 8 weeks of treatment if RBC transfusions are still required or there is no hemoglobin response.

If hemoglobin exceeds a level needed to avoid red blood cell transfusion: Withhold dose; resume treatment with a 25% dose reduction when hemoglobin approaches a level where transfusions may be required.

If hemoglobin increases GREATER THAN 1 g/dL in any 2-week period or hemoglobin reaches a level sufficient to avoid red blood cell transfusion: Reduce dose by 25%.

Nursing Orders

☒ **Hypersensitivity Reaction Adult Oncology Protocol**

Until discontinued Starting when released Until Specified

Treatment Parameters

☒ **ONC MONITORING AND HOLD PARAMETERS**

For adult patients with CKD not on dialysis OR with chemotherapy induced anemia, administer if Hgb within previous 7 days is less than 10 g/dL. If Hgb is 10g/dL or greater, contact provider prior to administration.

For adult patients with CKD on dialysis OR anemia due to myelodysplastic syndromes (MDS), administer if Hgb within previous 7 days is less than 11 g/dL. If Hgb is 11g/dL or greater, contact provider prior to administration.

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Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED:		**VALIDATED:**		**ORDERED:**			
TIME	**DATE**	**TIME**	**DATE**	**TIME**	**DATE**	Pager #	
	Sign		**R.N. Sign**		**Physician Print**		**Physician Sign**

EPIC VERSION DATE: 07/16/20

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