BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

ERYTHROPOIETIN STIMULATING AGENTS (ESA) ORDER
BOT OUTPATIENT USE ONLY

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:
Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

INSURANCE INFORMATION:
Please attach a copy of insurance cards (front and back)

MEDICAL INFORMATION

Patient Weight: _____ lbs. (required) Height: _____ Diabetic ☐ Yes ☐ No

Allergies: _____

Primary Diagnosis: _____ ICD-10: _____

INDICATION: (Must check one)

- ■ Chronic kidney disease
- ■ End Stage Renal Disease (Non-dialysis dependent)
- ■ End Stage Renal Disease (Dialysis dependent)
- ■ Chemotherapy-induced anemia
- ■ Symptomatic anemia associated with myelodysplastic syndrome (MDS)
- ■ Other:_____

A. GUIDELINES FOR ORDERING:

1. Baseline* serum ferritin and transferrin saturation (TSAT) levels should be ordered or provided upon initiation of therapy.
2. For chemotherapy induced anemia indication, treatment intent must be palliative and provider must have discussed risk versus benefit with patient.

B. LABS:

- ■ Serum ferritin and transferrin saturation ordered ONCE, at baseline*
- ■ Hemoglobin and hematocrit ONCE ☐ Weekly ☐ Monthly ☐ Other:_____
- ■ Serum ferritin and transferrin saturation ONCE ☐ Weekly ☐ Monthly ☐ Other:_____
- ■ Erythropoetin ONCE at baseline* Other: _____
- ■ Folate and B-12 ONCE at baseline* Other: _____
- ■ Serum iron and TIBC ONCE ☐ Weekly ☐ Monthly ☐ Other:_____

**Within 90 days and reflective of patient's current status*

C. MEDICATIONS: Outpatient orders are valid for 6 months

Physician must indicate the following: HOLD for Hemoglobin ≥ _____ g/dL and/or (circle one) Hematocrit ≥ _____ %

1. ESA

a. Epoetin alfa-epbx (Retacrit®) subcutaneously, ONCE
Retacrit® is the preferred BOT Epoetin-alfa product. If insurance denies Retacrit® or other reason not to prescribe Retacrit®, must indicate brand desired:_____

Dose: (must check one)

☐ 2,000 units ☐ 4,000 units ☐ 20,000 units ☐ _____Units
☐ 3,000 units ☐ 10,000 units ☐ 40,000 units

Interval:
☐ Weekly x _____ weeks
☐ _____ times per week x _____weeks

B. Darbepoetin (Aranesp®) subcutaneously, ONCE
Dose: (must check one)

☐ 25 mcg ☐ 60 mcg ☐ 150 mcg ☐ 300 mcg
☐ 40 mcg ☐ 100 mcg ☐ 200 mcg ☐ 500 mcg

Interval:
☐ Every _____ Weeks x _____ Doses
☐ Monthly

2. ESA weight based dosing

a. Epoetin alfa-epbx (Retacrit®)- Retacrit® is the preferred BOT Epoetin-alfa product
If insurance denies Retacrit® or other reason not to prescribe Retacrit®, must indicate brand desired: _____
Dosing: _____ units/kg = _____ units subcutaneously, ONCE
(Pharmacy to round dose to nearest vial size if within 5% of original dose)

Interval:
☐ Weekly x _____ weeks
☐ _____ times per week x _____weeks

b. Darbepoetin (Aranesp®) 0.45 mcg/kg = _____ mcg subcutaneously, ONCE
(Pharmacy to round dose to nearest vial size if within 5% of original dose)

Interval:
☐ Every _____ Weeks x _____ Doses
☐ Monthly

_____Verbal or telephone order read back and verification complete _____

receiver's initials *Physician Signature* *ID Number* *Date/Time*