



Trinity Health Muskegon & Shelby Infusion Clinics

Muskegon: 1500 Sherman BLVD, Muskegon, MI 49444

Shelby: 72 S. State St. Shelby, MI 49455

Fax (shared): 231-672-3970

Darbepoetin alfa (Aranesp®)

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. Trinity Health Muskegon will obtain any necessary medication authorizations for patients receiving infusion therapies

Order Date: ___/___/___ Site of Service: TH Muskegon TH Shelby

Referral Status: New Referral Dose or Frequency Change Renewal

Patient Name: _____ Date of Birth: ___/___/___ Weight: ___kg Height: ___cm Allergies: _____	Primary Insurance: _____ Member ID: _____ Secondary Insurance: _____ Member ID: _____
<p style="text-align: center;">Diagnosis</p> Diagnosis Code (ICD-10): _____ Indication: _____ CKD Stage: _____ Target start date: _____	<p style="text-align: center;">Lab Orders</p> <input type="checkbox"/> Prior to first treatment (within 45 days) CBC w/diff, Scr, Ferritin, Transferrin, Iron, Folic Acid, Vitamin B12, Erythropoietin level <input type="checkbox"/> Prior to each treatment: CBC w/diff <input type="checkbox"/> Every 3 months: ferritin, transferrin and iron <input type="checkbox"/> Annually: Folate and Vitamin B12
<p>Notify provider and hold dose/ dose adjustment at provider discretion for:</p> <p>Hemoglobin: <input type="checkbox"/> > 11 g/dL <input type="checkbox"/> Hg increase > 1 g/dL over 2 weeks <input type="checkbox"/> Other: _____</p>	
<p>Rx Darbepoetin alfa (Aranesp) subcutaneous injection</p> <p><input type="checkbox"/> _____mcg <input type="checkbox"/> Weekly <input type="checkbox"/> 0.45 mcg/kg <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> 0.75 mcg/kg <input type="checkbox"/> Every 4 weeks <input type="checkbox"/> Other: _____</p>	
<p>Nursing Orders:</p> <p>Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary: sodium chloride 0.9 % bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN</p>	
Provider Name: _____ Office Phone Number: _____ Attending Physician Name: _____ <small>(If ordering provider is an advanced practice practitioner, attending physician required)</small> <small>Note: This order is valid for 12 months from date of physician signature.</small>	Provider Signature: _____ Office Fax Number: _____