Premier Health Infusion Center
Erythropoiesis Stimulating Agents (ESA) Order Form

_
Patient Name _____ MRN# _____Date of Birth _____

Patient's Allergies _____

Primary Insurance: _____

Ordering Provider_____ Provider Phone/Fax #_____/_____

Infusion Center Fax Numbers:

MVH Middletown: 513-974-5023
MVH South: 937-641-2676
MVH Troy: 937-440-4503
MVH North: 937-641-2378
MVH Greenville: 937-641-7205

DIAGNOSIS (Two Diagnosis Codes are Required for CKD not on dialysis, for dialysis check first two boxes):

Primary Diagnosis:

- ☐ Anemia in Chronic Kidney Disease (D63.1)
- ☐ End Stage Renal Disease (N18.6)
- ☐ Anemia due to antineoplastic chemotherapy (D64.81
- ☐ Encounter for antineoplastic chemotherapy (Z51.11)
- ☐ Myelodysplastic syndrome, unspecified (D46.9)
- ☐ Refractory anemia with ring sideroblasts (D46.1)
- ☐ Refractory anemia with excess of blasts, unspecified (D46.20)
- ☐ _____ (Include diagnosis code)

Secondary Diagnosis: (Must select a secondary diagnosis for stage of CKD)

- ☐ Chronic Kidney Disease, Stage 1 (N18.1)
- ☐ Chronic Kidney Disease, Stage 2 (N18.2)
- ☐ Chronic Kidney Disease, Stage 3 unspecified (N18.3)
- ☐ Chronic Kidney Disease, Stage 3a (N18.31)
- ☐ Chronic Kidney Disease, Stage 3b (N18.32)
- ☐ Chronic Kidney Disease, Stage 4 (N18.4)
- ☐ Chronic Kidney Disease, Stage 5 (N18.5)

LABS:

Labs that must be done prior to therapy: (must be within 30 days of initiation of therapy to ensure adequate iron stores)

Hemoglobin/Hematocrit result: _____ Date: _____

Tsat/Iron sat result: _____ Date: _____

Ferritin:_____ Date:_____

Labs to be done at infusion appointment if not done within 7 days of treatment:

- ☐ Hemoglobin/Hematocrit
- ☐ Other: _____

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ESA MEDICATION ORDERS:

☑ **If Hemoglobin ≥ 10, hold ESA dose. Repeat Hemoglobin at next appointment or in four weeks and if Hemoglobin < 10, restart ESA at next lower commercially available dose.**
Weight-based doses will be rounded to the nearest vial size as approved by System P&T (10/2023)

☐ **Epoetin alfa-epbx (Retacrit) (Preferred PH Agent)** (HCPCS Q5105 ESRD)

DOSE: _____units_(Subcutaneous) ☐ 3 times per week ☐ Weekly ☐ q2weeks ☐ other _____

☐ Epoetin alfa (Epogen/Procrit) (HCPCS Q4081 ESRD)

DOSE: _____units_(Subcutaneous) ☐ 3 times per week ☐ Weekly ☐ q2weeks ☐ other _____

☐ DARBepoetin (ARANESP) (HCPCS J0882 ESRD)

DOSE: _____mcg_(Subcutaneous) ☐ q2weeks ☐ q4weeks ☐ other _____

Additional Orders: _____

Provider signature_____

Printed provider name_____

Date_____ Time _____

Form revised: 3/2024