NEW ENGLAND
Cancer Specialists

Infusion Center

KENNEBUNK | ROCK ROW | TOPSHAM | PORTSMOUTH
PHONE: (207) 303-3225 | FAX: (207) 692-2473

Aranesp (Darbepoetin Alfa) Order Form

Patient Name _____ Middle _____ Last _____ DOB _____

Diagnosis _____ Diagnosis Code _____

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

INDICATION:

- ◯ Anemia due to chemotherapy
- ◯ Anemia due to chronic kidney disease (not on dialysis)
- ◯ Anemia due to chronic kidney disease (on dialysis)
- ◯ Other: _____

Administer darbepoetin if Hgb is less than the following level: * _____ gm/dL

DOSE (PLEASE SELECT DOSE FROM OPTIONS BELOW):

- ◯ 40mcg
- ◯ 100mcg
- ◯ 300mcg
- ◯ Other: _____
- ◯ 60mcg
- ◯ 200mcg
- ◯ 500mcg

FREQUENCY (PLEASE SELECT FREQUENCY FROM OPTIONS BELOW):

- ◯ Every 7 days
- ◯ Every 14 days
- ◯ Every 21 days
- ◯ Every 28 days

Orders valid through: _____

In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.

Provider Name _____ Provider Signature _____

Date _____ Phone _____ Fax _____ Pager _____