Patient Name:_____ **Date of Birth:** _____

Address: _____

Phone: _____ **ICD-10 Diagnosis:**_____

Rx:
Aranesp subcutaneous injection

Dose:
☐ 25 mcg
☐ 40 mcg
☐ 60 mcg
☐ 100 mcg
☐ 150 mcg
☐ 200 mcg
☐ 300 mcg
☐ 500 mcg
☐ Other: _____ mcg

Frequency:
☐ every 1 week
☐ every 2 weeks
☐ every 3 weeks
☐ every 4 weeks
☐ Other: every _____ weeks

If Hgb greater than or equal to 10 g per dL, hold Aranesp.

If patient's current dose is held for more than 2 sequential encounters, office will be contacted for further direction regarding dose and frequency.

Labs: will be drawn at each appointment or within 1 week
☐ Hemoglobin and Hematocrit
☐ CBC

Other labs to be done: _____
Frequency to other labs: _____
Iron studies and Ferritin every 3 months.

Order Duration: ☐ 3 months ☐ 6 months ☐ One year ☐ Other:_____

Prescriber printed name: _____

Prescriber full address:_____

Office phone number:_____ **Office fax number:**_____

_____ _____ _____
Prescriber signature Date Time

Questions? Call (419) 591-3858. Please fax complete form to (419) 592-4004.

HENRY COUNTY HOSPITAL
1600 East Riverview Ave • Napoleon, Ohio 43545
(419) 592-4015

ARANESP (DARBEPOETIN) ORDER FORM

ONC-72 040726