

<b>PHYSICIAN'S ORDER (EXCLUDING IV Fluids and MEDICATIONS)</b>	<b>INTRAVENOUS FLUID and MEDICATION ORDERS</b>
<p><b>EXCLUSION CRITERIA: Do not use Argatroban for any of the following conditions: (Check all that apply)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Severe hepatic insufficiency (Child-Pugh score &gt; 6 or LFTs &gt; 3x ULN)</li> <li><input type="checkbox"/> Therapeutic tPA given for ischemic stroke within 24 hrs</li> <li><input type="checkbox"/> Major active bleeding (ex: hemorrhage, GI bleeding)</li> <li><input type="checkbox"/> Increased risk of bleeding (brain, spinal cord surgery, epidural analgesia, spinal or lumbar puncture)</li> <li><input type="checkbox"/> Hypersensitivity to Argatroban or one of its components</li> <li><input type="checkbox"/> If baseline PTT &gt; 100 or INR &gt; 2.5, do NOT start Argatroban and notify attending physician</li> </ul> <p><b>INITIAL ORDERS: Suspected or Confirmed HIT (Check all that apply)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Positive serologic test for HIT (HIT antibody +)</li> <li><input type="checkbox"/> Thrombocytopenia: PLT &lt;100K or &gt;50% decrease from baseline</li> <li><input type="checkbox"/> History of HIT or Allergy to Heparin</li> <li><input type="checkbox"/> Clinical presentation of HIT with thrombosis (HITT)</li> <li><input checked="" type="checkbox"/> Discontinue all forms of Heparin/LMWH (IV, SC, flushes, catheters)</li> <li><input checked="" type="checkbox"/> Add Heparin/LMWH to allergy list and document in patient's medical records</li> <li><input checked="" type="checkbox"/> Label all IV sites or catheters "No Heparin" and post sign at bedside</li> <li><input checked="" type="checkbox"/> AVOID intramuscular (IM) or intrathecal injections while on Argatroban</li> </ul> <p><b>BASELINE LABS: Order prior to starting Argatroban if not obtained within previous 24 hrs</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> PTT, PT/INR</li> <li><input checked="" type="checkbox"/> Hemogram - H/H, RBC, WBC, PLT</li> <li><input checked="" type="checkbox"/> AST/ALT/Total Bilirubin</li> </ul> <p><b>INITIATION OF THERAPY (Choose ONE)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Begin Argatroban continuous infusion immediately following draw of baseline labs</li> <li><input type="checkbox"/> If patient on heparin, LMWH, warfarin, DOACs refer to Argatroban Infusion Protocol</li> </ul>	<p>ALLERGY: _____ WEIGHT: _____</p> <p><b>INITIAL DOSING: Actual body weight (Choose one)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Normal hepatic function: <b>2 mcg/kg/min</b></li> <li><input type="checkbox"/> Obese Dosing (50% over IBW): <b>1 mcg/kg/min</b></li> <li><input type="checkbox"/> Hepatic impairment: <b>0.5 mcg/kg/min</b></li> <li><input type="checkbox"/> Critically-ill with multiple organ dysfunction (MODS), heart failure, severe anasarca, post-cardiac surgery: <b>0.2 mcg/kg/min</b></li> </ul> <p><b>DOSE ADJUSTMENTS: (Max rate: 10 mcg/kg/min)</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Follow Argatroban Infusion Protocol to target therapeutic PTT levels (45-90 seconds)</li> <li><input checked="" type="checkbox"/> Consult Pharmacist to assist in managing Argatroban therapy for patient</li> <li><input checked="" type="checkbox"/> Follow Argatroban Infusion Protocol to discontinue or transition to another anticoagulant</li> </ul> <p><b>MONITORING PARAMETERS</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> PTT every 4 hours for 2 consecutive therapeutic levels after the start of infusion or after any dose adjustments, then may change to Daily aPTT</li> <li><input checked="" type="checkbox"/> Daily Hemogram - H/H, RBC, WBC, PLT</li> <li><input checked="" type="checkbox"/> AST/ALT/Total Bilirubin every 3 days if patient has or is suspected for hepatic impairment</li> <li><input checked="" type="checkbox"/> Assess for signs of bruising or bleeding and document daily rate of infusion in iMED</li> </ul> <div style="border: 1px solid black; height: 100px; width: 100%; background-color: #cccccc; margin: 10px 0;"></div> <p><b>See 2nd page: Argatroban Infusion Protocol &gt;&gt;&gt;&gt;&gt;&gt;&gt;</b></p> <p><b>Physician's Initial:</b> _____</p>

IVF and MEDICATION ORDERS ONLY

- Summary/Blanket orders are unacceptable.
- Medication orders must be complete.
- PRN medication orders must include an indication.
- Write legibly.
- Rewrite orders upon transfer and/or post-operatively.
- Date, time, and sign verbal & telephone orders within 48 hours.

- DO NOT USE:**
- U MS
  - IU MSO<sub>4</sub>
  - Q.D. MgSO<sub>4</sub>
  - Q.O.D. Trailing zero
  - Lack of leading zero

PATIENT ID LABEL

ITEMS WITH BOXES/PARENTHASES MUST BE CHECKED TO BE ORDERED. Orders that have been changed (additions, deletions, or strike outs) must be initialed by the ordering MD for the order to be valid.

**PHYSICIAN'S ORDER  
(EXCLUDING IV Fluids and MEDICATIONS)**

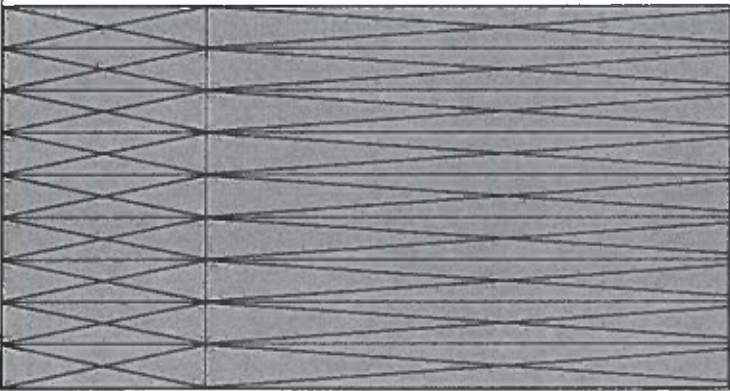
**ARGATROBAN INFUSION TITRATION PROTOCOL**

PTT in seconds	Standard (Normal liver function)	Hepatic Impairment (Moderate to Severe)	Critically Ill + Multi-organ Failure
< 45	Increase rate by 0.5 mcg/kg/min	Increase rate by 0.1 mcg/kg/min	Increase rate by 0.05 mcg/kg/min
45 - 90	Therapeutic - No change	Therapeutic - No change	Therapeutic - No change
91 - 100	Decrease rate by 0.5 mcg/kg/min	Decrease rate by 0.1 mcg/kg/min	Decrease rate by 0.05 mcg/kg/min
101-149	Hold infusion for 1 hour and Decrease rate by 50%	Hold infusion for 1 hour and Decrease rate by 50%	Hold infusion for 1 hour and Decrease rate by 50%
≥ 150	STOP infusion - Draw PTT every 4 hours until < 90, and contact MD for further orders	STOP infusion - Draw PTT every 4 hours until < 90, and contact MD for further orders	STOP infusion - Draw PTT every 4 hours until < 90, and contact MD for further orders

- Must obtain PTT every 4 hours for 2 consecutive therapeutic PTTs, obtain Daily PTT levels
- Maximum Rate of Infusion: **10mcg/kg/min**

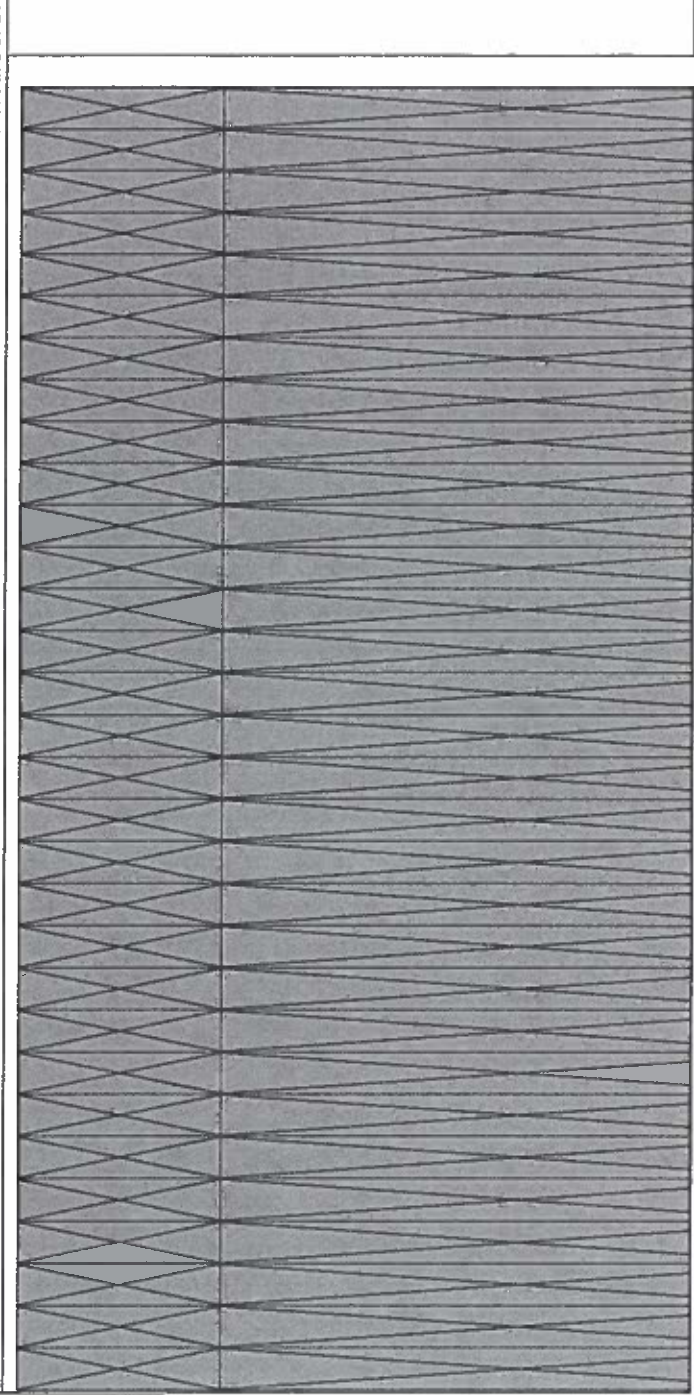
Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_



**INTRAVENOUS FLUID and MEDICATION ORDERS**

**ALLERGY:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_



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