(Place Patient Sticker Here)

PHYSICIAN'S ORDERS

HT: _____cm

WT: _____kg

DATE: _____

Allergies: **Heparin, Low-Molecular Weight Heparins** TIME: _____

HEPARIN-INDUCED THROMBOCYTOPENIA (DTI) PROTOCOL –BIVALIRUDIN

Orders completed by Nursing

1. Page Clinical Pharmacy Specialist / Coordinator for initiation and daily follow-up.
2. Order CBC without differential DAILY.
3. Draw baseline aPTT prior to infusion.
4. STAT aPTT 2 hours after the start of the continuous infusion and 2 hours after any rate change.
5. Stop all heparin or low-molecular weight heparin, including flushes or locks.
6. Label all IV sites or catheters as "NO HEPARIN"
7. Adjust rate of infusion based upon *Bivalirudin Dose Adjustment Instructions.*

BIVALIRUDIN DOSE ADJUSTMENT INSTRUCTIONS (Use Standard Concentration 1 mg / mL)	
aPTT (seconds)	Dose Adjustment /Monitoring
Greater than 75	Stop infusion for **1 hour** and then restart at **50%** slower rate. **(new rate=current rate/2)** ***(Reminder - Draw aPTT 2 (two) hours after each rate change)***
45-75	Continue at current rate. ***Draw aPTT in AM***
Less than 45	Increase infusion rate by **20%. (new rate=current rate x 1.2)** ***(Reminder - Draw aPTT 2 (two) hours after each rate change)***

8. Document the initiation, the rate, rate changes, and discontinuation on the *HIT Protocol Flow Record*
9. Document the time of aPTT lab draw and result on the *HIT Protocol Flow Record*
10. Discontinue daily CBC and aPTT when bivalirudin is discontinued
11. If any two sequential aPTTs exceed 75 seconds, page the Clinical Pharmacy Specialist On-Call/Coordinator at _____.

Orders for Pharmacist

1. Order bilateral lower extremity ultrasound for DVT if not already done
2. Discontinue active orders for any heparin or LMWH and add to allergy list
3. Calculate CrCl using Cockcroft-Gault equation

Initial Maintenance Infusion (250mg / 250ml NS or D5W)	
CrCl (ml/min)	**Dose (based on actual body weight)**
> 60	0.15 mg/kg/hr
30-59	0.08 mg/kg/hr
10-29 *or* CRRT	0.05 mg/kg/hr
< 10 *or* conv HD	0.02 mg/kg/hr

4. Enter initial infusion rate _____mL/hr

Orders for Physician

- ❑ Warfarin Dosing Service to follow & begin anticoagulation with warfarin after platelet count recovery & when physician specifies.
- ❑ Do not consult Warfarin Dosing Service. MD to manage warfarin.

Warfarin Management Recommendations (NOT ORDERS)

1. Do not start warfarin until platelets > 150,000 / mm^3
2. Use doses no greater than 5 mg to initiate warfarin therapy
3. Minimum of 5 days of overlap with bivalirudin and warfarin
4. **NOTE:** Bivalirudin slightly elevates the INR *in vitro*; therefore, overlap with warfarin until INR **greater than 3**
5. Once INR greater than 3 for 2 consecutive days, stop bivalirudin

Physician Signature: Physician number: Date/Time:

Signature Date