



BON SECOURS
RICHMOND HEALTH SYSTEM

ARGATROBAN PROTOCOL FOR HIT/ISOLATED HIT

ALL ORDERS MUST INCLUDE DATE, TIME,
AND PHYSICIAN'S SIGNATURE.

- Memorial Regional Medical Center
 Richmond Community Hospital
 St. Francis Medical Center
 St. Mary's Hospital

Place patient label inside box (if no patient label, complete below)

Name: _____

DOB: _____

MR #: _____

THIS PATIENT IS ALLERGIC TO

NKA

Date: _____ Estimated Length of Stay: _____

ORDER PATIENT STATUS: Observation Indication _____ (e.g., nausea, bleeding) Outpatient in a bed
 (additional time needed to evaluate pt's condition) (Normal recovery requiring acute care bed)
 Inpatient (meets medical necessity for admission) Outpatient procedure

Hospitalization certified necessary for the following reasons:

Plan of Care: See Progress Notes, H and P, and Physician Orders

D/C Plan: Home with Office Follow-up Home Health Care Rehabilitation Care Facility
 Extended Care Facility (e.g. Adult Home, Nursing Home, etc.) Other (Specify): _____

Physician Signature: _____

ORDERS (other than medications) CHECK ALL THAT APPLY

1. Patient must be in critical care or step down unit
2. Baseline PTT, PT/INR, Creatinine, CMP, HCT, Platelet Count
3. Platelet count every day
4. All PTTs are to be run stat
5. PTT 2 hr and 6 hr after initiation of Argatroban
6. PTT 4 hr after any dosage change until two consecutive PTTs are therapeutic (40-83 seconds) then change PTT to Qday
7. If PTT is greater than 100 seconds stop argatroban, draw PTT every 2 hours until PTT is 40-83 seconds then restart Argatroban at new rate (see Rate Chart)
8. Daily PT/INR after warfarin started as noted below
- a. If argatroban dose is greater than 2 mcg/kg/min, reduce argatroban to 2 mcg/kg/min for 4 hours, draw PT/INR, if PT/INR greater than 4, on warfarin and argatroban, stop argatroban, draw PT/INR four hours later, restart argatroban immediately after PT/INR drawn at original rate. Use second PT/INR for warfarin dosage adjustments.
- b. If argatroban dose is less than or equal to 2 mcg/kg/min Drawn PT/INR, if PT/INR greater than 4, on warfarin and argatroban, stop argatroban, draw PT/INR four hours later, restart argatroban immediately after PT/INR drawn at prior rate. Use second PT/INR for warfarin dosage adjustments.
9. Guaiac all stools, gastroccult all emesis, visually check for hematuria or other bleeding.
10. Notify physician immediately for unexplained drop in blood pressure, development of hematoma, drop in HCT, flank pain, bright red urine, bruising or other signs of bleeding.

MEDICATION & I.V. FLUID ORDERS CHECK ALL THAT APPLY

- Discontinue all Heparin, Heparin flushes, Enoxaparin (Lovenox) and Dalteparin (Fragmin)
- Discontinue Warfarin (Coumadin)
- Phytonadione (Vitamin K) 10 mg subQ x 1 (if the patient has been on Warfarin)
- Discontinue all IM injections (physician to give order for alternate route of administration)
- Argatroban infusion:
- 2 mcg/kg/min if hepatic disease score per table is less than or equal to 6
- 1 mcg/kg/min if creatinine clearance is less than 60 ml/min and hepatic disease score is less than or equal to 6.
- 0.5 mcg/kg/min if hepatic disease score per table is greater than 6
- Adjust Argatroban rate per PTT using Argatroban rate adjustment chart
- Pharmacy to send initial infusion rate chart and rate adjustment chart to floor with Argatroban infusion
- Warfarin (Coumadin) _____ mg (range 2 - 5 mg) Qday once platelet count is greater than 150,000 per mm³ Goal PT/INR while argatroban infusing at or below 2 mcg/kg/min is 4-5, off argatroban goal PT/INR is 2-3.
- Discontinue Argatroban when two consecutive daily INR are 2 to 3 (on Warfarin alone, see step 8 on left) and Warfarin therapy has overlapped Argatroban therapy for at least 5 days.

MR-PHY-2-79 (5/05)

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(SMH TAB #2)

MOST COMMON DO NOT USE ABBREVIATIONS, NOT AN ALL INCLUSIVE LIST:
 MS AS .Xmg OS µg Q.D.
 MSO4 AD X.0mg OD Q.O.D.
 MgSO4 AU IU OU TIW U

Physician Signature _____

Date / Time _____