Outpatient Anticoagulation Treatment Packet

Check when complete (If indicated):

☐ Primary Care Provider Follow

☐ Referral to Franciscan Transitional Clinic (if no primary care provider - information provided on primary care provider referral services)

☐ Outpatient DVT Treatment Physician Order

☐ Anticoagulation Clinic Referral –Complete EPIC Order “ref111f” (to be electronically signed by ED medical provider)

☐ Outpatient Anticoagulation Discharge Agreement Letter

☐ Outpatient Anticoagulation Treatment Program: Enrollment and Discharge Instructions (Select appropriate document based on treatment option scheduled)

☐ Enoxaparin and Warfarin prescriptions (ED medical provider to complete and sign) if option #1 selected

☐ Rivaroxaban (or alternative Xa inhibitor, based on insurance coverage) prescriptions (ED medical Provider to complete and sign) if option #2 selected

☐ Vouchers / Medication Assistance Algorithm complete (medication specific programs available)

☐ Patient education “Enoxaparin Discharge Kit” (if necessary)

☐ Patient education Warfarin material (if necessary)

☐ Patient education “Rivaroxaban Discharge Kit” (if necessary)

☐ Education provided and documented in patient chart on Enoxaparin, Warfarin, or Rivaroxaban (or alternative Xa inhibitor) and follow-up arranged

Please sign when complete
Pharmacist Name: ____________________________ Date: ________________
Outpatient DVT Treatment [30400736]

NOTE: IF PATIENT MEETS CRITERIA, CHOOSE 1 DVT TREATMENT REGIMEN, NOT BOTH

Exclusion criteria:
- Less than 18 years old
- Weight less than 35 kg
- Pregnant
- Active, known bleeding or excessive risk (PUD, GI, severe liver disease, thrombocytopenia)
- CVA, CNS/cord injury, or Major Surgery less than 10 days
- Renal Failure (serum creatinine greater than 3)
- Significant Cardiopulmonary disease
- Known Substance or Alcohol Abuse

### Labs

**Baseline Labs [128012]**

<table>
<thead>
<tr>
<th>Test Name</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemoglobin [LAB291]</td>
<td>Once</td>
</tr>
<tr>
<td>Hematocrit [LAB289]</td>
<td>Once</td>
</tr>
<tr>
<td>Platelet Count [LAB301]</td>
<td>Once</td>
</tr>
<tr>
<td>Protime-INR [LAB320]</td>
<td>Once</td>
</tr>
<tr>
<td>Hepatic Function Panel [LAB20]</td>
<td>Once</td>
</tr>
<tr>
<td>Creatinine, Serum [LAB66]</td>
<td>Once</td>
</tr>
</tbody>
</table>

### Outpatient Treatment

**Outpatient Treatment Regimen - LMWH + Warfarin [128015]**

- Give Warfarin after enoxaparin.

**ED Treatment Regimen – LMWH & Warfarin [157225]**

- **Enoxaparin (LOVENOX) Injection 1mg/kg [420334]**
  1 mg/kg, SubCutaneous, Now (expires in 36 hours), Starting today, For 1 Doses
  Give warfarin after enoxaparin.
  STAT

- **Warfarin (COUMADIN) Tablet [8748]**
  10 mg, Oral, Now (expires in 36 hours), Starting today, For 1 Doses
  Give warfarin after enoxaparin.
  STAT

- **Pharmacy To Dose Warfarin [PHA4]**
  STAT, Once

- **Pharmacy Dosing and Education – Lovenox/Warfarin [CON100]**
  Routine, Once, Pharmacist to notify provider if unable to complete education.

- **ED Provider to Arrange Follow-up with FMG/HHP provider, PCP, or Transition Clinic [NUR195]**
  Routine, Until discontinued, Starting today

Physician’s Initial: ____________________
## Discharge Treatment Regimen – LMWH & Warfarin [128014]

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enoxaparin (LOVENOX) Injection [105900]</td>
<td>Print, 10 Syringe, Refill: 0 Inject ________mL (______mg total) Under the skin every 12 (twelve) hours for 10 doses.</td>
</tr>
<tr>
<td>Ambulatory Referral to Anticoagulation Monitoring [REF111F]</td>
<td>Routine</td>
</tr>
</tbody>
</table>

## Outpatient Treatment Regimen - Rivaroxaban [157227]

### ED Treatment Regimen – Rivaroxaban [157226]

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rivaroxaban (XARELTO) Tablet [110250]</td>
<td>15 mg, Oral, Once (expires in 36 hours), For 1 Doses With food. STAT</td>
</tr>
<tr>
<td>Pharmacy Consult: Xarelto Dosing and Education [CON100]</td>
<td>STAT, Once, Pharmacist to notify provider if unable to complete education</td>
</tr>
<tr>
<td>ED Provider to Arrange Follow-up with FMG/HHP Provider, Routine, Until discontinued, Starting today PCP, or Transition Clinic [NUR195]</td>
<td></td>
</tr>
</tbody>
</table>

### Discharge Treatment Regimen - Rivaroxaban [128016]

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rivaroxaban (XARELTO) 15mg Tablet [112834]</td>
<td>Print, 42 tablet, Refill: 0 Take 1 tablet (15 mg total) by mouth 2 (two) times a day. For 21 days. Take with food.</td>
</tr>
<tr>
<td>Rivaroxaban (XARELTO) 20mg Tablet [112835]</td>
<td>Print, 9 tablet, Refill: 0 Take 1 tablet (20 mg total) by mouth daily with dinner. For 9 days. Starting day 22 (after completion of 15 mg twice per day dosing). Normal, 60 tablet, Refill: 0</td>
</tr>
<tr>
<td>Rivaroxaban (XARELTO) 20mg Tablet [112835]</td>
<td>Take 1 tablet (20 mg total) by mouth daily with dinner. Starting day 31.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>ORDERING PROVIDER PRINT NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>PROVIDER SIGNATURE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>RN ACKNOWLEDGED</th>
</tr>
</thead>
</table>
Please fax signed copy of this patient’s referral note back to the Anticoagulation Clinic. Patient will not be scheduled until completed form is received.

Patient Information
Name: ___________________________________________ DOB: _____ / _____ / _____ Sex:  ☐ Male ☐ Female

Home Address: _______________________________________________________________________

Home Phone: _________________________ Work Phone: _____________________ Allergies: ________________________

Past Medical History/Chronic Conditions: ___________________________________________________________________________

Target INR Range:  ☐ 2.0-3.0  ☐ 2.5-3.5  ☐ Other: _______

Check both boxes (required):  ☐ Long Term use of Anticoagulants  ☐ Encounter for therapeutic drug monitoring

Indication for Therapy:  ICD Code:________________ (required)

☐ PE  ☐ AFIB  ☐ Mitral Valve Disorder  ☐ CVA  ☐ Aortic valve disorder  ☐ MVR  ☐ AVR mechanical

DVT - specify location: __________________________

Congestive Heart Failure (CHF) – please indicate both the type and acuity:

Type:  ☐ Systolic  ☐ Diastolic  ☐ Unspecified

Acuity:  ☐ Acute  ☐ Chronic  ☐ Acute On Chronic  ☐ Unspecified

☐ Left Heart Failure  ☐ Unspecified  ☐ OTHER: ______________________

Duration of Therapy (referral must be renewed yearly):  ☐ 3 months  ☐ 6 months  ☐ 12 months  ☐ OTHER _______

☐ New Start Patient (initializing warfarin therapy)

Start therapy per protocol. Date to start: ____/____/____ Next PT/INR to be drawn: ____ /____/____

☐ Patient currently on Warfarin

Current Warfarin dose and schedule: __________________ Next PT/INR to be drawn: ____ /____/____

☐ PT on Fragmin or Lovenox (Please circle appropriate medication) - current dose __________

D/C Fragmin or Lovenox after ☐ 1, ☐ 2, ☐ other ______ in range INR’s

(American College of Chest Physicians Guidelines recommends 2 in range INR’s before D/C of LMWH.)

RPH to order additional Lovenox or Fragmin at above dose if INR not in range.

If number of in range INR’s is not indicated, the FHS Anticoagulation RPh will use CHEST Guidelines recommendations of two in range INR’s prior to d/c of LMWH.

Physician Information
Please be aware: you will need to manage your patients INR until the first visit with the anticoagulation Clinic. You will be notified via fax of patient’s first appointment.

Phone: ____________________________

Physician Name: ____________________________ FAX: ____________________________

Pager: ____________________________

Physician Signature: ____________________________ Date: ___/___/___ Email: ____________________________

By my above signature I the signing and managing physician agree to the Franciscan Health Systems Anticoagulation Clinic Protocol as approved by the Washington State Board of Pharmacy for the individual referred patient named above. I acknowledge that I will renew this individual patient’s referral annually. I the signing physician understand I will receive progress notes after each patient visit until patient obtains another care provider or until patient has discontinued anticoagulation medication or is no longer in need of anticoagulation therapy.

Updated Physician Signature: ____________________________ Date: ___/___/___

Updated Physician Signature: ____________________________ Date: ___/___/___

Updated Physician Signature: ____________________________ Date: ___/___/___

FHS ANTICOAG REFERRAL
LAST REVISED 2/4/2014
Outpatient Anticoagulation Discharge Agreement Letter

Date: _________________________________

Patient Name: __________________________

Address: ________________________________

City, State, ZIP: __________________________

Dear Patient: ____________________________

As per our agreement, participation in the Anticoagulation Treatment Program is not in any way to be considered the initiation of a patient/physician relationship. Participation in the program is limited to the treatment and management of your deep vein thrombosis (DVT) and anticoagulation therapy and only until such time that you are considered stable and/or have established a patient/physician relationship with a primary care provider.

At this time your condition is considered stable. However, since your condition, DVT, requires additional medical care please contact a new healthcare provider without delay.

Please contact one of the organizations below for assistance in finding a new primary care provider.

- Pierce County Medical Society Referral Services 253-572-3666
- King County Medical Society Referral Services 253-621-3963
- King County Public Health Center 253-838-4557
- Pierce County Public Health Center 253-798-2987
- Kitsap County Medical Society 866-844-9355

This is solely your responsibility.

Your failure to seek recommended follow up treatment may create complications or crisis that can cause permanent harm or death. Should your medical condition require immediate treatment prior to selecting a new healthcare provider, you are instructed to seek emergency care at the nearest location.

Sincerely,

ED Medical Provider __________________________ Date __________________________

ED Pharmacist __________________________ Date __________________________
Outpatient Anticoagulation Treatment: Enoxaparin (Low Molecular Weight Heparin) & Warfarin
Enrollment and Discharge Instructions

You have been selected to receive treatment in the outpatient anticoagulation program. Participation in the outpatient treatment program is not in any way to be considered the initiation of a patient/physician relationship. This treatment program is designated to provide transitional care for your deep vein thrombosis (DVT) until such time that you establish a patient/physician relationship with a primary care physician. In an effort to provide the most effective care and to prevent future complications, in order to participate in this program you must agree to the following:

- You agree to contact the Central Scheduling Office if referred from the St. Joseph Medical Center, St. Francis Hospital, St. Clare Hospital or St. Anthony Hospital at 253-573-7470 to set up your initial intake appointment within 3-5 days of discharge.
- You agree to contact the Highline Medical Center Anticoagulation Clinic if referred by Highline Medical Center at 206-988-5714 to set up your initial intake appointment within 3-5 days of discharge.
- You agree to work with the anticoagulation clinic to schedule ongoing appointments, all of which you are expected to keep.
- You agree to establish a patient/physician relationship with a primary care physician within the next 2 weeks.
- Your follow-up is in your ED discharge instructions and you have read these thoroughly and understand the instructions.

Referral Sources:

- Pierce County Medical Society Referral Services 253-572-3666
- King County Medical Society Referral Services 253-621-3963
- King County Public Health Center 253-838-4557
- Pierce County Public Health Center 253-798-2987
- Kitsap County Medical Society 866-844-9355

- You agree to take your medication as prescribed
- You agree to obtain blood draws as prescribed
- You agree to report to the nearest emergency room if the following symptoms (bleeding, swelling, chest pain, shortness of breath, or similar symptoms) occur and/or if you have a change in your current health status.
- If asked to follow up at one of the Franciscan Medical Group (FMG) clinics you agree to schedule and keep the appointment as directed.

Your instructions for care are as follows:

- Receive your first dose of Enoxaparin and Warfarin while in the Emergency Department
- Receive an educational Enoxaparin teaching kit (VHS/DVD, teaching book, alcohol swabs, sharps container)
- Receive Warfarin education material
- Obtain information and paperwork for anticoagulation clinic referral and follow-up
- Receive two prescriptions: Enoxaparin and Warfarin

Fill your prescriptions immediately. For your convenience the Enoxaparin (LMWH), and Warfarin are available at any of the Franciscan Pharmacies at St. Joseph, St. Clare, St. Francis and/or St. Anthony (please see location information below), or you may fill your prescriptions at your local community pharmacy.
Franciscan Pharmacy and Home Medical Supply at St. Joseph
1608 S. J St.
Tacoma, WA 98405
Pharmacy: 253-274-7650
Hours: Monday-Friday, 7:30 a.m.-6 p.m.
Saturday, 9 a.m.-5 p.m. (closed 12:30-1 p.m.)

Franciscan Pharmacy and Compounding, St. Clare
11315 Bridgeport Way S.W., Suite A1087, Lakewood
Phone: Pharmacy: 253-985-6290; Supplies: 253-426-6912
Hours: Monday-Friday, 9 a.m.-5 p.m. (closed 12:30-1 p.m.)

Franciscan Pharmacy, Franciscan Medical Pavilion - Canyon Road
15214 Canyon Road E., Suite 110, Puyallup
Phone: Pharmacy: 253-539-6030
Hours: Monday-Friday, 9 a.m.-5 p.m. (closed 12:30-1 p.m.)

Franciscan Pharmacy and Home Medical Supply, St. Francis
34503 Ninth Ave., Suite 110, Federal Way
Phone: Pharmacy: 253-944-4040
Hours: Monday-Friday, 9 a.m.-5 p.m. (closed 12:30-1 p.m.)

If you have any questions or concerns, please contact the emergency department.

Sincerely,

__________________________________________  Date
ED Medical Provider

__________________________________________  Date
ED Pharmacist

Initial:

____ I understand the terms of participation in this program and consent to the conditions of the agreement and my responsibilities as outlined above.

____ I understand that participation in this program is limited to treatment and management of my DVT through anticoagulation therapy and only until such time as I am stable and/or I establish a patient/physician relationship with a primary care provider within the time constraints listed above.

____ I understand that participation in this program requires that I actively work to establish a patient/physician relationship with a primary care provider.

____ I understand that participation in this program does not include treatment and/or management of any other health condition I may have.

__________________________________________  Date
Patient Signature
Dear Patient: 

Outpatient Anticoagulation Treatment: Rivaroxaban (or alternative Xa inhibitor)  
Enrollment and Discharge Instructions

You have been selected to receive treatment in the outpatient anticoagulation program. Participation in the outpatient treatment program is not in any way to be considered the initiation of a patient/physician relationship. This treatment program is designated to provide transitional care for your deep vein thrombosis (DVT) until such time that you establish a patient/physician relationship with a primary care physician. In an effort to provide the most effective care and to prevent future complications, in order to participate in this program you must agree to the following:

- You agree to establish a patient/physician relationship with a primary care physician within the next 2 weeks.
- You agree to work with your primary care physician to schedule ongoing appointments, all of which you are expected to keep.
- Your follow-up is in your ED discharge instructions and you have read these thoroughly and understand the instructions.

Referral Sources:
- Pierce County Medical Society Referral Services 253-572-3666
- King County Medical Society Referral Services 253-621-3963
- King County Public Health Center 253-838-4557
- Pierce County Public Health Center 253-798-2987
- Kitsap County Medical Society 866-844-9355

- You agree to take your medication as prescribed
- You agree to obtain blood draws as prescribed
- You agree to report to the nearest emergency room if the following symptoms (bleeding, swelling, chest pain, shortness of breath, or similar symptoms) occur and/or if you have a change in your current health status.
- If asked to follow up at one of the Franciscan Medical Group (FMG) clinics you agree to schedule and keep the appointment as directed.

Your instructions for care are as follows:
- Receive your first dose of Rivaroxaban while in the Emergency Department
- Receive Rivaroxaban (or alternative Xa inhibitor) education material
- Receive two prescriptions: Rivaroxaban 15 mg twice daily for 21 days, THEN Rivaroxaban 20 mg daily thereafter for the duration determined by physician (3 months total)
  
  (Note: Based on patient specific insurance plans, your treatment medication may change to a similar drug within the same class of medication (Xa inhibitor) if it is considered a “preferred agent” by your insurance. Such drugs could include but are not limited to Apixaban or Edoxaban)

- Further dosing beyond 3 months is the responsibility of your primary care provider (if deemed appropriate)
- Discuss with Pharmacist the available patient medication assistance programs
- You may receive a follow-up phone call from a Pharmacist within the next month as part of monitoring and evaluation of Rivaroxaban (or alternative Xa inhibitor) therapy.

Fill your prescriptions immediately. For your convenience the Rivaroxaban (or alternative Xa inhibitor) are available at any of the Franciscan Pharmacies at St. Joseph, St. Clare, St. Francis and/or St. Anthony (please see location information below), or you may fill your prescriptions at your local community pharmacy.
If you have any questions or concerns, please contact the emergency department.

Sincerely,

ED Medical Provider ____________________________ Date __________

ED Pharmacist ____________________________ Date __________

Initial:

_____ I understand the terms of participation in this program and consent to the conditions of the agreement and my responsibilities as outlined above.

_____ I understand that participation in this program is limited to treatment and management of my DVT through anticoagulation therapy and only until such time as I am stable and/or I establish a patient/physician relationship with a primary care provider within the time constraints listed above.

_____ I understand that participation in this program requires that I actively work to establish a patient/physician relationship with a primary care provider.

_____ I understand that participation in this program does not include treatment and/or management of any other health condition I may have.

Patient Signature ____________________________ Date __________
Outpatient Anticoagulation Treatment Algorithm:
Enoxaparin (LMWH) & Warfarin

1. ED medical provider deems patient acceptable for outpatient treatment.

2. Patient meets inclusion/exclusion criteria.

3. Outpatient DVT Order and Anticoagulation Treatment Packet completed (including discharge prescriptions).

4. ED Medical Provider to complete electronic referral (ref 111f) within EPIC.

   Option #1 (If appointment can be confirmed prior to discharge from ED): ED pharmacist (if available) may confirm appointment time and date with the Central Scheduling referral line at 253-573-7470 if the discharge is from the St. Joseph Medical Center, St. Francis Hospital, St. Clare Hospital or St. Anthony Hospital during business hours. ED pharmacist (if available) may confirm appointment time and date with the Highline Medical Center Anticoagulation Clinic at 206-988-5714 if the discharge is from the Highline Medical Center during business hours.

   Option #2 (If appointment can not be confirmed prior to discharge from ED): During non-business hours, a message may be left by the ED pharmacist (if available) to confirm the EPIC referral has been received and the appointment is being arranged. In this case, the patient must also call to the confirm time and date of 3-5 day appointment upon discharge from the ED.

5. ED Medical Provider to arrange follow-up with Franciscan Medical Group, Primary Care Provider or Transition Clinic (if no primary care provider)

6. The Anticoagulation Clinic appointment will be scheduled within 3-5 business days after receipt of the referral. ED pharmacist (if available) to inform patient they should expect a call within 24-72 hours to set up the initial anticoagulation visit.

7. If the patient does not have follow up within the required 3-5 days, they will not be accepted for enrollment in the Anticoagulation clinic and will be required to seek further medical care at the emergency department.

8. ED Pharmacist (if available) to educate patient on LMWH and warfarin therapy utilizing “LMWH teaching kit” and “FHS Warfarin Booklet”

9. For EPIC downtime, please use attached Anticoagulation Clinic Referral Form
Outpatient Anticoagulation Treatment Algorithm:
Rivaroxaban (or alternative Xa inhibitor)

1. ED Medical provider deems patient acceptable for outpatient treatment.

2. Patient meets inclusion/exclusion criteria.

3. Outpatient DVT Order and Anticoagulation Treatment Packet completed (including discharge prescriptions).

4. ED Pharmacist (if available) to call the outpatient pharmacy to determine if rivaroxaban therapy will be covered by insurance. If an alternative Xa inhibitor is deemed the insurance formulary agent of choice, consult the medical provider to change the outpatient prescriptions to the alternative formulary agent.

5. ED Pharmacist (if available) to complete Patient Assistance Algorithm (agent specific) and assist the patient with the necessary enrollment forms (online or via telephone) to attain authorization for “Saving / Co-pay Cards” or “Free trial” vouchers/offers when necessary if requested by ED Medical provider.

6. ED Pharmacist (if available) to assist in the prior authorization process if requested by ED Medical provider.

7. ED Medical provider to arrange follow-up with Franciscan Medical Group, Primary Care Provider or Transition Clinic (if no primary care provider).

8. ED Pharmacist (if available) to educate patient regarding rivaroxaban (or alternative Xa inhibitor) therapy utilizing the “Rivaroxaban Patient Education Guide”
Call outpatient pharmacy and determine if Rivaroxaban is covered by patient’s insurance (if not covered, determine alternative Xa inhibitor formulary agent of choice). Assist patient to attain authorization for “Savings / Co-pay Cards” or “free trial” vouchers /offers.

If Rivaroxaban (or alternative Xa inhibitor) access cannot be insured, recommend an alternative DVT treatment modality (Enoxaparin + Warfarin)

Insurance Coverage Unavailable

Available Programs:
Johnson & Johnson Patient Assistance Foundation (http://jjpaf.org/)
or
Bristol –Meyers Squibb Patient Assistance Foundation http://www.bmspaf.org/Pages/Home.aspx

Determine if patient meets eligibility criteria, complete all required forms, and provide patient with appropriate documentation / copies

Medicare, Medicare Part D, Medicaid

Available Programs:
Xarelto CarePath Program (Online / Phone approval 1-888-927-3586) (#30 days free trial offer)
or
Eliquis 360 Support Program (Phone approval 1-855-354-7847) (#30 day free trial offer)

Note: In most instances, Medicare and Medicaid provide comprehensive drug coverage for their enrolled patients. They typically do not qualify for medication assistance programs beyond the free trial offers

Commercial (Non-Medicare/Medicaid) Insurance Providers

Available Programs:
Xarelto CarePath Program (Online / Phone approval 1-888-927-3586) (#30 days free trial offer and no monthly out-of-pocket costs for commercial insurance)
or
Eliquis 360 Support Program (Phone approval 1-855-354-7847) (#30 day free trial offer and $10 / month out of pocket costs for commercial insurance)