

EDUCATIONAL GUIDELINE

For

Outpatient Treatment of Acute DVT with Low-Molecular-Weight Heparin

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(Updated Feb. 25, 2001)

EXCLUSION CRITERIA

Absolute contraindications

Allergy or sensitivity to heparin	Active bleeding
Active peptic ulcer disease	Symptomatic pulmonary embolus
GI bleed within the last 6 months	Bleeding disorder
Significant hepatic insufficiency or failure	Epidural anesthesia
Severe HTN, (>220 syst, >120 diastolic)	Catheter-associated DVT
Major or active co-morbid illness (CHF, sepsis)	Familial bleeding disorder
History of Heparin-induced thrombocytopenia	Ileo-femoral DVT
Renal insuff. (Creat >2.0 or Creat. cl <30cc/min)	Platelet count <100,000
(note: LOVENOX is renally excreted and elimination is delayed in patients with renal failure)	

Relative contraindications—clinical

Asymptomatic PE (not approved for this)	Age >75 yr
Significant abnormal PT, PTT, Plat. count	Severe leg swelling and pain
Two or more previous episodes of DVT, PE	Abdominal skin infection
Congenital/acquired hypercoagulable state	Pregnancy (safety data rapidly appearing)
Morbid Obesity (>150 Kg)	Weight <35 Kg

Relative contraindications—Psychosocial/economic

Geographic inaccessibility	Likelihood of non-compliance
Increased risk of falls	History of substance abuse
Language barrier	Inability to pay for LMWH
Unstable home environment	Telephone inaccessibility
Incompetence to assume responsibility of self-care or inability of family/friend/nurse to Administer care.	

DVT TREATMENT GUIDELINES

Stat CBC, PT/INR, PTT, serum creatinine if not obtained in the past 24 hrs.

If PT/INR is normal, platelet count is >150,000 and serum creatinine is <2.0 mg%, LOVENOX (enoxaparin) can be administered subcutaneously at 1mg/kg actual body weight every 12 hours (round to the nearest 10 mg). Note: If patient is on continuous IV Heparin, the infusion is stopped and the first dose of LOVENOX can be administered 1 hour after heparin is DC'd.

All calculations to be done in Kilograms (Kg).

Coumadin- the first dose should be administered no less than 3 hr. after the initial LOVENOX injection.

Coumadin can be given in the same way as usual and Coumadin and LOVENOX are to be given concurrently for a minimum of 5 days, as is the case with heparin/coumadin administration.
ENOXAPRIN can be discontinued when the INR is therapeutic (INR 2-3) for 2 consecutive days.

CBC with particular attention to platelets to be obtained every other day while on LOVENOX.

A daily protime is obtained and the coumadin dose adjusted according to the INR.
Nurse should notify MD for signs of bleeding or if the platelet count is <150,000.

CBC every other day should be discontinued once LOVENOX is discontinued.

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Bibliography

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LOVENOX ANTICOAGULATION PATIENT ASSISTANCE PROGRAM
OFFERED BY AVENTIS PHARMACEUTICALS AND OSF MEDIPARK PHARMACY

- Form needs to be completed and signed by the physician and patient
- Consult Discharge Planner for economic guidelines
- Attach prescription to the completed form
- Patient takes form/script to OUR OSF MediPark Pharmacy
- Patient pays \$5.00 fee to MediPark for the Lovenox
- MediPark dispenses the medication to patient and files the paperwork with Aventis

Contact Discharge Planner or Case Manager with any questions or concerns
Chris Teuerle, RN, MS, Vascular Case Manager, Office: 624-9337 - Pager: 497-8551

AVENTIS PHARMACEUTICALS INC.
LOVENOX® (enoxaparin sodium) Injection PATIENT ASSISTANCE PROGRAM

RETURN FORM TO: Caremark Inc., Therapeutic Services Division

Fax (888) 875-9951 Phone (888) 632-8607

Requirements:

- Original application must be completely filled out by physician and patient
- Third-party insurance must be verifiable
- If ZERO INCOME, send letter verifying patient's source of subsistence

*******PRESCRIPTION MUST BE ATTACHED TO THIS APPLICATION*******

THIS SECTION MUST BE COMPLETED BY THE INDIVIDUAL REFERRING PATIENT	
Name of Individual referring patient:	
Facility Name:	Phone Number:
Street Address:	
City, State, Zip:	
If hospitalized, name of hospital:	Phone Number:
Discharge Date:	
THIS SECTION MUST BE COMPLETED BY THE ATTENDING PHYSICIAN	
Physician Name:	
Is this a Non-Profit Clinic:	
DEA / MD #:	Phone Number:
Product Requested / Dosage -	
Concomitant Drugs (Please List):	
ADDRESS TO DELIVER PRODUCT TO (MD or Hospital pharmacy only ---NO P.O. BOX):	

I request that the medication listed above be provided to me for the following patient who has medical and financial need for assistance and, has no other resource for obtaining the above prescribed medication. I certify that there are no legal, statutory, or regulatory obligations requiring that the medication listed above be provided to the patient. I certify that the product requested is for outpatient utilization only.

Physician's Signature _____ Date: _____

**THIS SECTION MUST BE COMPLETED BY THE PATIENT					
Patient Name:			Additional Family Contact:		
Address:					
S.S. #:		Phone #:		Date of Birth:	
Previous Aventis Patient Assistance Recipient: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, state when:					
GROSS MONTHLY INCOME FOR HOUSEHOLD – Must be completely filled out					
Family Status (Number of dependents upon primary income):					
Salary / Wages	\$	Unemployment Compensation	\$		
Social Security	\$	Pension	\$		
Social Security Supplemental Income	\$	Investment Income	\$		
Disability	\$	Total	\$		
HEALTH INSURANCE					
	Yes	No		Yes	No
Medicaid			Employer Insurance		
Medicare			State Medical Aid		
Private Insurance			Veteran's Assistance		
PPO/HMO/Prescription Plan			Other federal or state funded benefit program		

I certify that the foregoing information is accurate, that I have exhausted all benefits available under any federal or state funded benefit program or coverage under any third party insurance, and am unable to afford the medication requested. I authorize Aventis and Caremark Inc. to use the information on this form in the processing of my patient assistance request and to disclose this information to third parties for purposes of investigating available benefits, coordinating care and determining eligibility under the program and authorize the use of my Social Security number for identification purposes and record keeping.

Patient's Signature _____ Date: _____