

## Heparin Orders – LOW DOSE ReoPro/Integrilin/Thrombolytics for Acute MI/Neurology/Vascular & Surgical Patients

Date/Time	Physician Order		
	<p><b>ALLERGIES</b> _____ <b>HT</b> _____ <b>ft/in</b> <b>WT</b> _____ <b>lbs</b></p> <p>PTT --patients having received thrombolytic for Acute MI; patients receiving Integrilin for medical management (not going to catheterization lab or prior to catheterization lab)</p> <p>ACT -- patients receiving ReoPro; patients receiving Integrilin after returning from the catheterization laboratory</p> <p><b>LABORATORY</b></p> <ol style="list-style-type: none"> <li>1. Obtain CBC, PTT, PT prior to initiation of heparin therapy if not already done in previous 24 hours.</li> <li>2. Order a PTT or ACT 6 hours after any dosage change, adjusting the heparin infusion by the sliding scale until PTT or ACT is within the therapeutic range. When two consecutive laboratory values are therapeutic, order PTT or ACT (and readjust the heparin drip as needed) every 12 hours. See #8 below.</li> <li>3. Obtain CBC every third day unless otherwise ordered during heparin therapy.</li> </ol> <p><b>NURSING</b></p> <ol style="list-style-type: none"> <li>4. Continue dosing based on initial weight. If patient weight changes 10 lbs or more, rewrite the orders with new dose.</li> <li>5. Check if patient has received previous heparin bolus, heparin infusion, low molecular weight heparin (examples: Lovenox or Fragmin) or Xigris (drotrecogin alfa). If patient has received either within 12 hours, contact physician prior to starting further heparin.</li> <li>6. Do not start new order for low molecular weight heparin (i.e. Lovenox or Fragmin) or Xigris (drotrecogin alfa) until notifying physician of current heparin infusion.</li> <li>7. <b>Use heparin dosing chart for infusion rates and adjustments.</b></li> <li>8. Order a PTT or ACT 6 hours after any dosage change, adjusting the heparin infusion by the sliding scale until PTT or ACT is within above therapeutic range. When two consecutive laboratory values are therapeutic, order PTT or ACT (and readjust the heparin drip as needed) every 12 hours</li> <li>9. Obtain stat PTT or ACT and call physician if evidence of bleeding.</li> <li>10. Discontinue CBC's and PTT/ACT's when heparin discontinued.</li> <li>11. Daily weight if diuresing.</li> <li>12. Minimize IM injections while on heparin infusion.</li> </ol> <p><b>PHARMACY</b></p> <ol style="list-style-type: none"> <li>13. Dosing based on total body weight: _____ lb = _____ kg (wt in lb x 0.45) (<b>round down to the nearest 5 lbs</b>)                     <ul style="list-style-type: none"> <li>• <u>Loading dose:</u> <ul style="list-style-type: none"> <li><input type="checkbox"/> 60 units/kg = _____ units IV push, <b>maximum 4,000 units</b>. Hold if already received at other facility.</li> <li><input type="checkbox"/> Optional: No bolus</li> </ul> </li> <li>• <u>Maintenance dose infusion</u> (Heparin premix, 25,000 units in 250 mL 0.45% sodium chloride = 100 units/mL):                              12 units/kg/hour = _____ mL/hour on an infusion pump, <b>max. initial dose 1000 units/hour (10 mL/hr)</b>.</li> </ul> </li> <li>14. Obtain PTT or ACT every 6 hours after initiation of heparin infusion.</li> </ol>		
	<b>PTT(seconds)</b>	<b>Action USE FLOWCHART FOR DOSING</b>	<b>ACT(seconds)</b>
	Less than 65	Give bolus of heparin of 60 units/kg = _____ units, and increase drip by 3 units/kg/hour = _____ mL/hour	Less than 150
	65-74	Give bolus of heparin of 30 units/kg = _____ units, and increase drip by 1.5 units/kg/hour = _____ mL/hour	150-200
	<b>75-105</b>	<b>Maintain current rate of infusion (therapeutic range)</b>	<b>201-250</b>
	106-116	Reduce the rate of drip by 2 units/kg/hour = _____ mL/hour	251-300
	Greater than 116	Hold the heparin for one hour, and then reduce the rate of drip by 3 units/kg/hour = _____ mL/hour	Greater than 300
	_____ Physician Signature  _____ Date/Time		

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