

**REMINDER: ALL MEDICATION ORDERS REQUIRE DOSE, ROUTE, FREQUENCY AND INDICATION
DO NOT USE ABBREVIATIONS**

DOCTORS ORDERS HEPARIN INDUCED THROMBOCYTOPENIA ARGATROBAN TO WARFARIN(COUMADIN®) PROTOCOL	CHECK OFF/ INITIALS
Discontinue all Heparin therapy including flushes and Heparin coated catheters	
Obtain baseline APTT and LFT's	
<input type="checkbox"/> Begin Argatroban® infusion at 2 mcg/kg/min OR <input type="checkbox"/> Begin Argatroban® infusion at 0.5 mcg/kg/min for hepatic insufficiency	
APTT 2 hours post initiation of Argatroban therapy and titrate to 1.5-3 times baseline (do not exceed 100 seconds) increasing in increments of 0.5mcg/kg/min When platelet levels normalize, begin Warfarin (Coumadin®) at ___ mg daily ***DO NOT USE A LOADING DOSE FOR WARFARIN (Coumadin®)***	
Monitor APTT and INR daily <input type="checkbox"/> (if infusion rate is greater than 2mcg/kg/min, reduce to 2mcg/kg/min one hour prior to obtaining INR Maintain Combination therapy for a minimum of 3 days	
<input type="checkbox"/> INR less than 4 – Increase Warfarin (Coumadin®) to ___mg daily <input type="checkbox"/> INR greater than or equal to 4 - Discontinue Argatroban® and recheck INR in 4-6 hours <input type="checkbox"/> INR within therapeutic range <input type="checkbox"/> INR below therapeutic range	
If INR is below therapeutic range, begin Argatroban® infusion and adjust Warfarin (Coumadin®) dose to ___mg daily Pharmacy consult for Warfarin (Coumadin®) therapy	
NO ADJUSTMENT IS NEEDED FOR RENAL INSUFFICIENCY	

Physician/Date/Time:	Nurse/Date/Time:	Secretary/Date/Time:
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Full page of orders requires only one physician, one nurse and one clerical signature



Original to Patient's Chart