

ADULT HOME HEMODIALYSIS STANDING ORDERS - VITAMIN D

IV Vitamin D Monitoring and Dosing:

A. Goals:

iPTH 200-300pg/ml
Ca⁺<9.5 mg/dl
PO₄ 3.5-5.5 mg/dl

B. Criteria for IV Vitamin D use in Home Hemodialysis (HH):

1. Funding for home administration of Zemplar, Calcijex or Hectorol will be verified. (ICD9 588.81)
2. If on Zemplar prior to entering HH
 - a. Continue same Zemplar dose used prior to entering HH.
 - b. If changing to Calcijex, locate current Zemplar dose on IV Vitamin D Dosing Table to find the equivalent Calcijex dose.
 - c. If changing to Hectorol, locate current Zemplar dose on IV Vitamin D Dosing Table below to find the equivalent Hectorol dose.
3. Stop oral Calcitriol or other equivalent.
4. Change patient to Standard Ca⁺⁺ (3.0mdq/L) dialysate if serum Ca⁺⁺ ≤8.5 mg/dl (if on B. Braun): if >8.5mg/dl 2.5 ca bath
5. Serum Ca⁺ is < 10.2 mg/dl
6. Calcium x PO₄ product < 65
7. If albumin is <3.0g/dL, notify physician for Ca⁺⁺ bath adjustment (for the B-Braun).
8. iPTH > 300dg/mL

C. Home Dialysis Lab Monitoring for Patients on IV Vitamin D:

1. iPTH (ICD9= 588.81) When starting IV VitD. for iPTH > 300 monitor iPTH monthly for the first three months than quarterly thereafter. Jan-April-July-Oct.
2. If iPTH is in the 200-300 range monitor iPTH quarterly. Jan-April-July-Oct.
3. If iPTH is <200 monitor monthly for 3 months then quarterly thereafter. Jan-April-July-Oct.
4. If iPTH remains <200 for >6 months monitor iPTH semi-annually. Jan-July
5. If IV Vit D is on hold for either elevated calcium or calcium x phosphorus product, check Ca⁺⁺, (ICD9=275.42) and PO₄ (ICD9=275.3) every 2 weeks x 2 and monthly thereafter.
6. Check Ca⁺⁺, (ICD9=275.42) and PO₄ (ICD9=275.3) every 2 weeks x 2 after dose change and monthly thereafter.
7. iPTH one month after dose change.

Patient Name: _____ NKC# _____

D. IV Vitamin D Dosing:

1. **Initial dose for patients not on IV Vitamin D** the dose will be set based on most recent iPTH per the IV Vitamin D Dosing Table below.

IV Vitamin D Dosing Table:								
Intact iPTH	Zemplar Dose IV (3x/week) mcg	Calcijex Dose IV (3x/week) mcg	Hectorol Dose IV (3x/week) mcg		Intact iPTH	Zemplar Dose IV (3x/week) mcg	Calcijex Dose IV (3x/week) mcg	Hectorol Dose IV (3x/week) mcg
0-300	None	None	None		900-999	12	2.5 mcg	5
301-399	2	1.0 mcg	2		1000-1099	12	3.0 mcg	6
400-499	4	1.5 mcg	2		1100-1299	14	3.0 mcg	6
500-599	6	1.5 mcg	3		1300-1499	16	3.0 mcg	6
600-699	8	2.0 mcg	4		1500-1699	18	3.0 mcg	6
700-799	10	2.5 mcg	4		1700-1799	20	3.0 mcg	6
800-899	10	2.5 mcg	5		>1800	Consult Physician	Consult Physician	Consult Physician

2. **Dose Adjustments:**

- a. If iPTH decreases from last PTH adjust dose according to IV Vitamin D dosing table above based on the current iPTH value.
- b. If iPTH is 200-300 maintain current dose.
- c. If iPTH increases adjust dose to the current level of iPTH based on the IV Vitamin D dosing table above.
- d. If after 3 months the iPTH fails to decrease or the iPTH has increased from the last iPTH within the same iPTH range increase the current dose by 1 mcg for Zemplar; or by 0.5mcg for Calcijex; or by 1mcg for Hectorol.

E. Maximum Dose:

1. **DO NOT EXCEED** Zemplar 30 mcg IV TIW
2. **DO NOT EXCEED** Calcitriol 3 mcg IV TIW
3. **DO NOT EXCEED** Hectorol 6 mcg IV TIW

F. Criteria to Hold IV Vitamin D:

1. iPTH < 150
2. Serum calcium >10.2 mg/dL.
3. Calcium x phosphorus product \geq 65

G. Criteria to Resume IV Vitamin D:

1. iPTH > 300 and
2. Serum calcium is < 10.2 and
3. Calcium x phosphorus product < 65
4. If on Zemplar resume per table below.

Patient Name: _____ NKC# _____

Zemplar dose (IV 3xweek) mcg before HOLD	Resume Zemplar at (IV 3xweek) mcg		Zemplar dose (IV 3xweek) mcg before HOLD	Resume Zemplar at (IV 3xweek) mcg
2	2mcg 2x/week			
4	2		18	14
6	4		20	16
8	6		22	16
10	8		24	18
12	10		26	20
14	12		28	20
16	12		30	22

5. If on Calcijex resume at 0.5mcg less than dose at the time it was held.
6. If on Hectorol resume at 1 mcg less than dose at the time it was held.
7. If vitamin D remains on hold for more than 3 months, notify MD.

Physician Name (Print): _____

Physician Signature: _____

Date: _____

R.N. Name (Print): _____

R.N. Signature: _____

Date: _____

Patient Name: _____ NKC# _____