NORTHWEST Kidney Centers

Levocarnitine Administration Order Form

The following criteria must be met to **initiate** levocarnitine therapy

Criteria		**Criteria Checklist**
1. Must have been on dialysis:	> 6 months	☐ Yes ☐ No
2. Must have plasma-free carnitine level:	< 40 micromols/L ICD-10 E71.43	☐ Yes ☐ No
3. Must have at least one of the following:		
a. EPO-Resistant Anemia (EPO dose 30,000 units/week and Hgb < 10)	ICD-10 D63.1	☐ Yes ☐ No
AND/OR		
b. Chronic Unresponsive Intradialitic Hypotension (Hypotension on hemodialysis that interferes with delivery of the intended dialysis despite application of usual measures)	ICD-10 I95.3	☐ Yes ☐ No

The following criteria must be met to **continue** levocarnitine therapy beyond 3 months

1. **Improvement** of EPO-Resistant Anemia	☐ Yes ☐ No
AND/OR	
2. **Improvement** of Chronic Unresponsive Intradialytic Hypotension	☐ Yes ☐ No

Please fax completed form to NKC Pharmacy: 206-343-4884

☐ Initial Order ☐ Order Continuation

Give LEVOCARNITINE 1 gram IV post dialysis 3 times per week for 3 months

_____ _____

Physician Signature Date

Patient Name: _____ NKC# _____