Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO9031

ADULT AMBULATORY INFUSION ORDER

Fosphenytoin Infusion for Trigeminal Neuralgia

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Severe hypotension and cardiac arrhythmias may occur with rapid administration (may be fatal) and commonly occur in critically ill patients, elderly patients, and patients with hypotension and severe myocardial insufficiency.
3. Use with caution in patients with hypotension and/or severe myocardial insufficiency; use is contraindicated in patients with sinus bradycardia, sinoatrial block, second- and third-degree heart block or Adam-Stokes syndrome.
4. Provider confirms that patient has been assessed for cardiac risk associated with fosphenytoin infusion and patient is appropriate for ambulatory administration without cardiac monitoring.

LABS:

- ☐ Complete Metabolic Panel, Routine, ONCE, every visit
- ☐ HCG Qual, Urine, Routine, ONCE, every visit, for patients of childbearing potential
- ☐ Labs already drawn. Date: _____

NURSING ORDERS:

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
2. Vital signs at baseline, every 15 minutes during infusion and for at least 20 minutes after completion of the infusion.
3. Avoid small hand veins and instruct patient to immediately report any pain or burning at IV site. Prior to administration, check IV blood return. At completion of administration, check for blood return and flush with at least 30 mLs of normal saline from flush bag.
4. Instruct patient that serious, delayed skin reactions can occur and to call MD if any purplish discoloration and/or swelling in lower arms or any other skin reactions occur.

MEDICATIONS:

Fosphenytoin (CEREBYX) in sodium chloride 0.9%, intravenous, ONCE, administer over 60 minutes

Dose: (Fosphenytoin dose is 15-20 mg PE/kg for trigeminal neuralgia)

- ☐ 15 mg PE/kg
- ☐ 20 mg PE/kg
- ☐ Other: ____ PE/kg

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HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

Please check the appropriate box for the patient's preferred clinic location:

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610