ADULT AMBULATORY INFUSION ORDER

Antibiotic Therapy

(Aminoglycosides, Daptomycin, & Glycopeptides)

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. Monitor drug levels and adjust dose as necessary.
    a. DAPTOmycin: draw Creatine Phosphokinase (CPK) - Plasma, Weekly. Monitor CPK more frequently in patients with recent prior or concomitant therapy with an HMG-CoA reductase inhibitor, unexplained CPK increases, or renal impairment
    b. Vancomycin: draw trough level just before the 4th dose and once weekly.
    c. Aminoglycosides: For daily dosing, draw random level 12 hours after the start of infusion and once weekly. For every 8-12 hour dosing, draw peak and trough weekly. Troughs are drawn just before the dose and peaks are drawn 30 minutes after the end of the dose.

NURSING ORDERS:

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

Aminoglycosides:

LABS:

- ☐ CBC with differential, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ CMP, every_____(visit)(days)(weeks)(months) – Circle One
- ☐ **Urine Dipstick w/o micro (10 dip), weekly during therapy**

Daily dosing

- ☐ **Random** _____ **level, 12 hours post-dose, weekly during therapy**

Traditional dosing

- ☐ **Peak** _____ **level, weekly during therapy**
- ☐ **Trough** _____ **level, weekly during therapy**

- ☐ Labs already drawn. Date: _____

MEDICATION:

- ☐ amikacin _____ mg/kg = _____mg in sodium chloride 0.9% 100 mL IV, over 30-60 minutes
- ☐ gentamicin _____ mg/kg = _____ mg in sodium chloride 0.9% 100 mL IV, over 30-60 minutes
- ☐ tobramycin _____ mg/kg = _____ mg in sodium chloride 0.9% 100 mL IV, over 20-60 minutes

Interval: (must check one)

- ☐ ONCE
- ☐ Daily x ____ doses
- ☐ Every ____ days x ____ doses

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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DAPTOmycin:

LABS:
- ☐ CBC with differential, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ CMP, every_____(visit)(days)(weeks)(months) – Circle One
- ☐ **CK, PLASMA, ONCE prior to therapy**
- ☐ **CK, PLASMA, weekly during therapy**
- ☐ Labs already drawn. Date: _____

MEDICATION:
- ☐ DAPTOmycin _____ mg/kg = _____ mg
  In sodium chloride 0.9% 50 mL IV over 30 minutes, or 50 mg/mL IV push over 2-4 minutes (500 mg or less over 2 minutes, greater than 500 mg over 4 minutes) per infusion facility practice.

Interval: (must check one)
- ☐ ONCE
- ☐ Daily x ____ doses
- ☐ Every ____ days x ____ doses

Dalbavancin:

LABS:
- ☐ CBC with differential, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ CMP, every_____(visit)(days)(weeks)(months) – Circle One
- ☐ C-reactive protein, every_____(visit)(days)(weeks)(months) – Circle One
- ☐ Labs already drawn. Date: _____

MEDICATION:

☐ **Single dose regimen**

dalbavancin (DALVANCE) **1500 mg** in dextrose 5%, intravenous, ONCE, over 30 minutes
Interval: ONCE

☐ **Two-dose regimen**

dalbavancin (DALVANCE) **1000 mg** in dextrose 5%, intravenous, ONCE, over 30 minutes
Interval: ONCE
&
dalbavancin (DALVANCE) **500 mg** in dextrose 5%, intravenous, ONCE, over 30 minutes
Interval: ONCE, 7 days after initial dose

☐ **Other**

dalbavancin (DALVANCE) _____ mg in dextrose 5%, intravenous, ONCE, over 30 minutes

Interval: _____

Vancomycin:

LABS:
- ☐ CBC with differential, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ CMP, every_____(visit)(days)(weeks)(months) – Circle One
- ☐ **Vancomycin trough, weekly during therapy (first level prior to 4th dose)**
- ☐ Labs already drawn. Date: _____

MEDICATION:
- ☐ vancomycin 750 mg in sodium chloride 0.9% 150 mL IV
- ☐ vancomycin 1000 mg in sodium chloride 0.9% 250 mL IV
- ☐ vancomycin 1250 mg in sodium chloride 0.9% 250 mL IV
- ☐ vancomycin 1500 mg in sodium chloride 0.9% 300 mL IV

Infuse doses up to 1000 mg over at least 60 minutes and doses greater than 1000 mg over 120 minutes. Infusion rate not to exceed 17 mg/min

Interval: (must check one)
- ☐ ONCE
- ☐ Daily x ____ doses
- ☐ Every ____ days x ____ doses

FOR InfuSystem™ AMBULATORY PUMP USE (OHSU only; hook up at infusion location):

Duration:
- ☐ _____ days

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

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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