OUTPATIENT INFUSION ORDER

ALLERGIES *(required)*

REACTIONS *(required if patient has an allergy)*

ALLERGIES

REACTIONS

DATE/TIME

PATIENT STATUS = OUTPATIENT

DIAGNOSIS: *(required)*

ORDER EXPIRATION DATE:
(SIX MONTHS MAX)

ORDER: (Name of Medication, Dose, Route and Frequency):

- **Pt. weight:** _____ Kg
- **PRE-SCREENING (required):**
  TB testing completed on _____*(Date)* **Result**: Positive or Negative *(Circle one)*
  HBV Screening completed on _____*(Date)* **HBV Status**: Positive or Negative *(Circle one)*

- **PRE-MEDICATIONS** (Administer 30 mins prior to infusion): *Place a check to select medication(s)*
  - ☐ acetaminophen 650 mg PO ONCE, every visit
  - ☐ loratadine 10 mg PO ONCE, every visit
  - ☐ Other:_____
  - ☐ diphenhydramine 25 PO ONCE, every visit
  - ☐ diphenhydramine 50 PO ONCE, every visit

- **MEDICATION:** Abatacept (Orencia)
  DOSE: *(SELECT a dose)*
  : ☐ **500 mg** (<60 kg) ☐ **750 mg** (60-100 kg) ☐ **1,000 mg** (>100 kg)
  ROUTE: and Duration: Administer intravenously over 30 minutes
  Initial Interval: ***SELECT*** *the order(s) by placing a check mark in the box*
  ☐ **Once** ☐ **0 week** (1st dose) ☐ **2 weeks** (2 weeks from 1st dose) ☐ **4 weeks** (4 weeks from 1st dose)
  ☐ Other:_____
  Reason for other: _____
  Maintenance Interval: (Must check one and fill in the blanks)
  ☐ Every 4 weeks for _____ doses.
  ☐ Other:_____
  Reason for other: _____

- **OBTAIN** vital signs on at the start and end of infusion.
- **DISCHARGE** patient if vital signs are within baseline.

RBV
Initials:

*Date: *Time: *Sign: MD#:

MEDICATIONS WILL BE PROCESSED ACCORDING TO THE GENERIC / THERAPEUTIC EQUIVALENT OR STANDARD PROCEDURES APPROVED BY THE PHARMACY AND THERAPEUTICS COMMITTEE. DEVIATIONS MUST BE SPECIFIED BY "DO NOT SUBSTITUTE."

Salinas Valley HEALTH
450 East Romie Lane, Salinas, CA 93901
831-757-4333 | Toll-free 888-755-7864

NS 7176-035940 (Rev. 10/24)

TIME & DATE REQUIRED

POINFOP

OUTPATIENT INFUSION ORDER

***NAME:**

***Date of Birth (DOB):**

OUTPATIENT INFUSION ORDER

ALLERGIES

REACTIONS

ALLERGIES

REACTIONS

DATE/TIME

PATIENT STATUS = OUTPATIENT

DIAGNOSIS:

ORDER EXPIRATION DATE:
(SIX MONTHS MAX)

ORDER: (Name of Medication, Dose, Route and Frequency):

***Select type of line:**

☐ **PICC Line** ***Discontinue*** PICC line on:

- Flush each lumen with 5 ml of Heparin 10 units/ml (50 units) IV prior to discharge. May use Saline flush as an alternative for Heparin allergy.
- Change PICC line dressing every 7 days (3 days if using gauze dressing) and PRN soiled or wet.

☐ **Implanted Port**

- Access port and flush each lumen with 5 ml of Heparin 100 units/ml (500 units) IV prior to de-accessing port. May use Saline flush as an alternative for Heparin allergy.

☐ **Tunneled CVC**

- Flush each lumen with 10 mL Normal Saline daily
- Change dressing every 7 days (2 days if using gauze dressing) and PRN soiled, wet, or no longer occlusive.

☑ **Peripheral Line** insert and discontinue prior to discharge.

☑ **For clotted PICC Line or Implanted Port:** Use Alteplase (Cathflo Activase) 2 mg IV ONCE for each line as needed to de-clot lumen(s). May repeat x1 for each lumen, if unable to de-clot the first time.

☑ **Insert peripheral line for hypersensitivity reactions and administer SVH medication as indicated.**

- Diphenhydramine 50 mg IV push x 1 PRN hives, itching, flushing, swollen lips or tongue
- Famotidine 20 mg IV push x 1 PRN hives, itching, flushing swollen lips or tongue
- Albuterol inhaler 2 puffs PRN SOB, tachypnea or decreased oxygen saturation
- Epinephrine 0.3 mg (Epi-Pen) IM may repeat x 2 at 5 min intervals PRN bronchial constriction (dyspnea, wheezing, stridor), hypotension
- Methylprednisolone 125 mg IV push PRN hypersensitivity reaction, to prevent biphasic reaction
- Meperidine 25 mg IV x 1 PRN rigors
- Oxygen Protocol PRN for SOB, tachypnea
- Acetaminophen 650 mg PO PRN fever/chills x 1 (if not given as pre-med)
- Montelukast 10 mg PO PRN wheezing, cough, hives, flushing x 1
- Normal Saline 1000 mg Start at TKO for medication administration, Bolus for SBP < 30 mmHg difference from baseline.

*Date: *Time: *Sign: MD#:

RBV
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