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):

Tezepelumab (Tezspire) 210 mg subcutaneously ONCE every 4 weeks
for total _____ treatment.

- Primary care physician to ensure patient immunizations are up to date before starting Tezspire.

☑ **Insert peripheral line and administer SVH hypersensitivity medications for reaction(s) 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
- Montelukast 10 mg PO PRN wheezing, cough, hives, flushing x 1
- Acetaminophen 650 mg PO PRN fever/chills x 1 (if not given as pre-med)
- Oxygen Protocol PRN for SOB, tachypnea
- Normal Saline 1000 mg Start at TKO for medication administration, Bolus for SBP ≤ 30 mmHg difference from baseline

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

RBV
Initials:

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):**