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.

☑ **Start Normal Saline infusion at 30 ml/hr.** After infusion of the last medication, flush the line with 50 ml at the same rate as the infused medication rate. Discontinue fluids after flushing. May use D5W if medication is incompatible with Normal Saline

*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):**

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)

Any dose changes or adjustments requires replacement of this order.

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)*

  Hepatitis B Testing completed on _____ *(Date)* **Result**: Positive or Negative *(Circle one)*

- **PRE-MEDICATION: (***Select all that apply)*
  - ☐ Diphenhydramine 25 mg **PO** ONCE ☐ Diphenhydramine 25 mg **IV** ONCE
  - ☐ Acetaminophen 650 mg **PO** ONCE
  - ☐ Others: _____
- **MEDICATION:** Tocilizumab (Actemra)

  Pharmacist will dose based on most recent weight and round to nearest vial size

  - **Initial Interval:** *(Must check one)* ☐ Once ☐ Every 4 weeks for _____total dose

    DOSE (*SELECT* a dose):
    - ☐ **6 mg per kg** in 0.9% sodium chloride, intravenous over 1 hour
    - ☐ **4 mg per kg** in 0.9% sodium chloride, intravenous over 1 hour
    - ☐ **8 mg per kg** (***MAX DOSE* 800 mg)** in 0.9% sodium chloride, intravenous over 1 hour
    - ☐ _____**mg** ***OR*** ____ **mg/kg** in 0.9% sodium chloride, intravenous over 1 hour

    ☐ ***Must*** check if provider has clinically determined that patient treatment should exceed MAX DOSE.

  - **Maintenance Interval:** Every 4 weeks for total _____ doses

    DOSE (*SELECT* a dose):
    - ☐ **6 mg per kg** in 0.9% sodium chloride, intravenous over 1 hour
    - ☐ **4 mg per kg** in 0.9% sodium chloride, intravenous over 1 hour
    - ☐ **8 mg per kg** (***MAX DOSE* 800 mg)** in 0.9% sodium chloride, intravenous over 1 hour
    - ☐ _____**mg** ***OR*** ____ **mg/kg** in 0.9% sodium chloride, intravenous over 1 hour

    ☐ ***Must*** check if provider has clinically determined that patient treatment should exceed MAX DOSE.

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

RBV
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OUTPATIENT INFUSION ORDER

ALLERGIES

REACTIONS

ALLERGIES

REACTIONS

DATE/TIME

PATIENT STATUS = OUTPATIENT

DIAGNOSIS:

ORDER EXPIRATION DATE: (SIX MONTHS MAX)

Any dose changes or adjustments requires replacement of this order.

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

- **Labs:**
  - Attach CBC, CMP results for the first 3 treatments; THEN, every 3 months
  - Provider will monitor patient laboratory results prior to each treatment and cancel treatment, if needed, due to abnormal lab values.

☐ **Provider authorizes administration of medication with lab results pending**

- **Nursing Orders:**
  - **DO NOT** treat, **NOTIFY** provider, and **DISCHARGE** patient if:
    - Last laboratory results are greater than 8 weeks
    - Reports having infection or being treated for infection or have signs/symptoms of infection, abdominal pain/discomfort, fatigue, dark urine or jaundice
    - pregnant or possibly be pregnant

☑ **Insert peripheral line and administer SVH hypersensitivity medication(s) for reaction 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 $\leq$ 30 mmHg difference from baseline

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