ADULT AMBULATORY INFUSION ORDER

Antiviral Therapy

Page 1 of 3

Patient Identification

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

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. If using this order form to request antivirals from a home health agency, specify interval and duration of therapy at the bottom of the order. May use ambulatory InfuSystem™ pump for antiviral administration if needed.
3. Foscarnet is reserved for ganciclovir-resistant CMV, and should not be used for CMV prophylaxis or pre-emptive treatment.
4. Both ganciclovir and foscarnet should be dose adjusted for renal impairment. Please contact pharmacist for dose adjustments when CrCl is less than 70 mL/min.

LABS:
- CBC with differential, Routine, ONCE, every______ (visit)(days)(weeks)(months) – Circle One
- CMP, Routine, ONCE, every______ (visit)(days)(weeks)(months) – Circle One
- Labs already drawn. Date: __________

MEDICATIONS:

ganciclovir (CYTOVENE) in NaCl 0.9% 100 mL, intravenous, ONCE, over 60 minutes

<table>
<thead>
<tr>
<th>Induction</th>
<th>Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 mg/kg</td>
<td>ONCE</td>
</tr>
<tr>
<td>2.5 mg/kg</td>
<td>Daily x ______ doses</td>
</tr>
<tr>
<td>1.25 mg/kg</td>
<td>Every ______ days x ______</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Maintenance</th>
<th>Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 mg/kg</td>
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</tr>
</tbody>
</table>
foscarnet (FOSCAVIR) in NaCl 0.9%, intravenous, ONCE

**Induction**
- **90 mg/kg**
- _____ mg/kg

**Interval**
- **ONCE**
- Daily x _____ doses
- Every _____ days x _____

**Maintenance**
- **120 mg/kg**
- _____ mg/kg

**Interval**
- **ONCE**
- Daily x _____ doses
- Every _____ days x _____

Infuse through: *(must check one)*
- Central line (concentration 24 mg/mL, over 1-2 hours)
- Peripheral line (concentration 12 mg/mL, over at least 1 hour)

Hydration:
- sodium chloride 0.9% 1000 mL, intravenous, over 1 hour, prior to initial foscarnet dose or over 1-2 hours during subsequent doses

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

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

**Frequency**:
- Q6H
- Q8H
- Q12H
- Daily
- Once every _____ days
- Continuous infusion, rate: ____________ per _________

**Duration**:
- _____ days
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: _____________

OLC Central Intake Nurse:
Phone: 971-262-9645 (providers only) Fax: 503-346-8058

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

□ Beaverton
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

□ NW Portland
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

□ Gresham
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

□ Tualatin
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders