**ADULT AMBULATORY INFUSION ORDER**  
**Pentamidine (PENTAM)**  

**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. 12 Lead ECG should be completed prior to treatment with pentamidine. Results MUST be faxed with this order set to be kept on record within the infusion pharmacy’s electronic medical record.  
3. Avoid use in patients with diagnosed or suspected congenital long QT syndrome.  
4. Use with caution in patients with pre-existing hypotension. Severe hypotension including fatalities, has been observed even after a single dose.  
5. Use with caution in patients with pre-existing cardiovascular disease, diabetes mellitus, or hypocalcemia.  
6. Use with caution in patients receiving nephrotoxic drugs such as aminoglycosides, amphotericin B, cisplatin, foscarinet, or vancomycin.  

**OTHER:**  
- [ ] 12 Lead ECG, routine, ONCE every ______ weeks  

**LABS:**  
- [ ] CMP (includes blood glucose), Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One  
- [ ] Glucose (serum), Routine, ONCE, every ______ (visit)(days)(weeks)(months) – Circle One  
- [ ] CBC with differential, Routine, ONCE, weekly during therapy  
- [ ] CBC with differential, Routine, ONCE, every_____ (visit)(days)(weeks)(months) – Circle One  
- [ ] Labs already drawn. Date: ____________

**MEDICATIONS:**  

pentamidine (PENTAM) in dextrose 5% 250 mL, intravenous, ONCE  
- [ ] 300 mg  
- [ ] 3 mg/kg = ______ mg  
- [ ] 4 mg/kg = ______ mg  

Infuse slowly over 1-2 hours. Vesicant. Flush line with D5W before and after infusion.

**Interval:** (must check one)  
- [ ] Once  
- [ ] Once daily x _____ doses  
- [ ] ____ times per week x ____ doses  
- [ ] Monthly x ______ doses
NURSING ORDERS:
1. Review patient’s SCr, BUN, calcium, and blood glucose during each visit. Notify provider if laboratory values are abnormal.
2. VITAL SIGNS – Monitor patient’s blood pressure for hypotension during and after infusion
3. Instruct patient to lie supine during the infusion. Patient should rise slowly after administration to avoid dizziness and other potentially severe hypotensive effects.
4. This medication is a vesicant. Avoid extravasation. Assess catheter position before and during infusion
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

AS NEEDED MEDICATIONS:
1. prochlorperazine (COMPAZONE) tablet, 10mg, oral, AS NEEDED, x1 doses for nausea/vomiting
2. LORazepam (ATIVAN) tablet, 1 mg, oral, AS NEEDED, x1 dose for nausea/vomiting. Hold if patient does not have a driver

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