ADULT AMBULATORY INFUSION ORDER

Antibiotic Therapy
(Daptomycin, Vancomycin, & Aminoglycosides)

**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 antibiotics from a home health agency, use a separate order set. May use ambulatory InfuSystem™ pump for antibiotic administration if needed.
3. Order culture and sensitivity tests as necessary.
4. Monitor drug levels and adjust dose as necessary.
   a. DAPTOmycin: draw Creatine Phosphokinase (CPK) - Plasma, Weekly. Monitor CPK more frequently in patients with recent prior or concomitant therapy with an HMG-CoA reductase inhibitor, unexplained CPK increases, or renal impairment
   b. Vancomycin: draw trough level just before the 4th dose and once weekly.
   c. Aminoglycosides: For daily dosing, draw random level 12 hours after the start of infusion and once weekly. For every 8-12 hour dosing, draw peak and trough weekly. Troughs are drawn just before the dose and peaks are drawn 30 minutes after the end of the dose.

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

DAPTOmycin:

LABS:
- CBC with differential, every _________ (visit)(days)(weeks)(months) – Circle One
- CMP, every _________ (visit)(days)(weeks)(months) – Circle One
- CK, PLASMA, ONCE prior to therapy
- CK, PLASMA, weekly during therapy
- Labs already drawn. Date: __________

MEDICATION:
- DAPTOmycin ______ mg/kg = ______ mg in NaCl 0.9% 50 mL IV, over 30 minutes

Interval: (must check one)
- ONCE
- Daily x _____ doses
- Every _______ days x _____ doses
Vancomycin:

LABS:
- CBC with differential, every ______ (visit)(days)(weeks)(months) – Circle One
- CMP, every ______ (visit)(days)(weeks)(months) – Circle One
- Vancomycin trough, weekly during therapy (first level prior to 4th dose)
- Labs already drawn. Date: ________

MEDICATION:
- Vancomycin 750 mg in NaCl 0.9% 150 mL IV
- Vancomycin 1000 mg in NaCl 0.9% 250 mL IV
- Vancomycin 1250 mg in NaCl 0.9% 250 mL IV
- Vancomycin 1500 mg in NaCl 0.9% 300 mL IV
  Infuse doses up to 1000 mg over at least 60 minutes and doses greater than 1000 mg over 120 minutes. Infusion rate not to exceed 17 mg/min

Interval: (must check one)
- ONCE
- Daily x _____ doses
- Every ______ days x ______ doses

Aminoglycosides:

LABS:
- CBC with differential, every ______ (visit)(days)(weeks)(months) – Circle One
- CMP, every ______ (visit)(days)(weeks)(months) – Circle One
- Urine Dipstick w/o micro (10 dip), weekly during therapy
  Daily dosing
  - Random ___________________ level, 12 hours post-dose, weekly during therapy
  Traditional dosing
  - Peak ___________________ level, weekly during therapy
  - Trough ___________________ level, weekly during therapy
- Labs already drawn. Date: ________

MEDICATION:
- Amikacin ______ mg/kg = ______ mg in NaCl 0.9% 100 mL IV, over 30-60 minutes
- Gentamicin ______ mg/kg = ______ mg in NaCl 0.9% 100 mL IV, over 30-60 minutes
- Tobramycin ______ mg/kg = ______ mg in NaCl 0.9% 100 mL IV, over 20-60 minutes

Interval: (must check one)
- ONCE
- Daily x _____ doses
- Every ______ days x _____ doses
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](http://www.ohsuknight.com/infusionorders)