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. Edaravone contains sodium bisulfite, a sulfite that may cause allergic type reactions, including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in susceptible people. Sulfite sensitivity occurs more frequently in asthmatic people.

NURSING ORDERS:

1. Do not use if the oxygen indicator has turned blue or purple before opening the package. Once the overwrap package is opened, use within 24 hours.
2. For first edaravone infusion, confirm patient does not have sulfite sensitivity. Edaravone contains sodium bisulfite, a sulfite that may cause a type of allergic reaction that can be serious and life-threatening. Sodium bisulfite can also cause less severe allergic reactions, for example, asthmatic episodes, in certain people. Sulfite sensitivity can happen more often in people who have asthma than in people who do not have asthma.
3. Monitor patient for hypersensitivity reaction, including anaphylaxis, for 30 minutes after edaravone administration.
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

MEDICATIONS:

- edaravone (RADICAVA) 60 mg, intravenous, over 60 minutes, ONCE, every visit

Interval:

☐ Initial cycle – Once daily for 14 days followed by a 14-day drug free period
☐ Subsequent cycle – Once daily for 10 days within a 14-day period, followed by a 14-day drug free period. Repeat x _______ cycles.
HYPERSENSITIVITY MEDICATIONS:
1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction
5. famotidine (PEPCID) 20 mg, intravenous, AS NEEDED x1 dose, for hypersensitivity reaction

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

- **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

- **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

- **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)