**ADULT AMBULATORY INFUSION ORDER**

**Pentamidine (PENTAM) Infusion**

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**Patient Identification**

- **ACCOUNT NO.**
- **MED. REC. NO.**
- **NAME**
- **BIRTHDATE**

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**Weight:** __________ kg  
**Height:** __________ cm

**Allergies:** __________________________________________________________

**Diagnosis Code:** _____________________________________________________

**Treatment Start Date:** __________  
**Patient to follow up with provider on date:** _________________

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**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, foscarnet, or vancomycin.

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**OTHER:**

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

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**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: __________

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**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.

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**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 (COMPAZINE) 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: __________________
Central Intake:
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