Oregon Health & Science University Hospital and Clinics Provider's Orders PO7071 ADULT AMBULATORY INFUSION ORDER **Amphotericin B Liposomal (AMBISOME) Infusion** Page 1 of 4	ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE *Patient Identification*

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. Order culture and sensitivitity tests as necessary.
3. Lipid-based and conventional formulations are not interchangeable and have different dosing recommendations. Lipid-based amphotericin formulations (AmBisome) may be confused with conventional formulations (desoxycholate [Amphocin, Fungizone]) or with other lipid-based amphotericin formulations (amphotericin B lipid complex [Abelcet], amphotericin B cholesteryl sulfate complex [Amphotec]).

LABS:

- ☐ Complete metabolic panel, routine, ONCE, every day
- ☐ CBC with differential, routine, ONCE, every day
- ☐ Magnesium, PLASMA, routine, ONCE, every day

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and notify provider if serum creatinine increases by greater than 0.5 mg/dL.
2. Existing intravenous line should be flushed with D5W before and after infusion.
3. HYPOKALEMIA:
   For potassium level 3.1 to 3.5 mmol/L, administer Potassium Chloride 40 mEq IV or PO.
   For potassium level less than or equal to 3 mmol/L, administer Potassium Chloride 60 mEq IV.
   For potassium level less than or equal to 2.5 mmol/L, administer Potassium Chloride 60 mEq IV and contact provider for further instruction.
4. HYPOMAGNESEMIA:
   For magnesium level of 1.3 to 1.5 mg/dL, administer Magnesium Sulfate 4 g IV.
   For magnesium level less than or equal to 1.2 mg/dL, administer Magnesium Sulfate 8 g IV.
5. VITAL SIGNS – For intial infusion monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion, then every 30 minutes until infusion is completed. For subsequent infusions monitor vital signs PRN with any symptoms of infusion reaction.

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PRE-MEDICATIONS: (Administer 30-60 minutes prior to infusion)
Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

- ☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit. Administer 30 minutes prior to infusion.
- ☐ diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit. Administer 30 minutes prior to infusion. Give either diphenhydrAMINE or loratadine, not both.
- ☐ loratadine (CLARITIN) tablet, 10 mg, oral, ONCE AS NEEDED, every visit, if diphenhydramine is not given. Administer 30 minutes prior to infusion. Give either loratadine or diphenhydrAMINE, not both.

MEDICATIONS:

Prehydration
- o sodium chloride 0.9%, 500 mL, intravenous, ONCE, every visit, over 60 minutes, Administer prior to amphotericin B LIPOSOME infusion.

amphotericin B LIPOSOME (AMBISOME)
- o _____ mg/kg = _____ mg in dextrose 5% diluted to 1 mg/mL, intravenous, ONCE, over 2 hours

Interval: (must check one)
- ☐ Daily x ____ doses
- ☐ Other: _____

Posthydration:
- o sodium chloride 0.9%, 500 mL, intravenous, ONCE, every visit, over 60 minutes, Administer following amphotericin B LIPOSOME infusion.

AS NEEDED MEDICATIONS:
1. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for infusion related fever.
2. diphenhydrAMINE (BENADRYL) capsule, 25 mg, oral, EVERY 4 HOURS AS NEEDED for itching.
3. meperidine (DEMEROL) injection, 12.5 mg, intravenous, EVERY 10 MINUTES AS NEEDED for infusion related rigors in the absence of hypotension, not to exceed 50 mg/hr.
4. Potassium chloride ER (Klor Con M) 40 mEq tablet, by mouth, ONCE AS NEEDED for K 3.1 to 3.5 mmol/L.
5. Potassium chloride 40 mEq in 0.9% sodium chloride 500 mL, intravenous, ONCE AS NEEDED for K 3.1 to 3.5 mmol/L via PERIPHERAL LINE and unable to tolerate oral potassium, over 4 hours.
6. Potassium chloride 20 mEq in sterile water for injection, 100 mL, intravenous, ONCE EVERY 2 HOURS AS NEEDED for K 3.1 to 3.5 mmol/L via CENTRAL LINE and unable to tolerate oral potassium, x2 doses for a total dose of 40 mEq, over 2 hours each for a total infusion time of 4 hours.
7. Potassium chloride 20 mEq in 0.9% sodium chloride, 250 mL, intravenous, ONCE EVERY 2 HOURS AS NEEDED for K less than or equal to 3 mmol/L via PERIPHERAL LINE, x3 doses for a total dose of 60 mEq, over 2 hours each for a total infusion time of 6 hours.
8. Potassium chloride 20 mEq in sterile water for injection, 100 mL, intravenous, ONCE EVERY 2 HOURS AS NEEDED for K less than or equal to 3 mmol/L via CENTRAL LINE, x3 doses for a total dose of 60 mEq, over 2 hours each for a total infusion time of 6 hours

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9. Magnesium sulfate 4 g in sterile water for injection, 100 mL, intravenous, ONCE AS NEEDED for Mag 1.3 to 1.5 mg/dL, over 2 hours
10. Magnesium sulfate 4 g in sterile water for injection, 100 mL, intravenous, ONCE EVERY 2 HOURS AS NEEDED for level less than or equal to 1.2 mg/dL, x2 doses for a total dose of 8 g, over 2 hours each for a total infusion time of 4 hours

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 (OHSU HC-PAT-133-GUD, HMC C-132). 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 x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion 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**: _____

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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