Oregon Health & Science University Hospital and Clinics Provider's Orders PO7071 ADULT AMBULATORY INFUSION ORDER **Pentamidine (PENTAM) Infusion** Page 1 of 3	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. 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.

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

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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

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