Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071

ADULT AMBULATORY INFUSION ORDER

Valproate And Magnesium Infusion for Migraine

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Treatment Start Date: _____ Allergies: _____

Weight: _____kg Height: _____cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety

1. **FACE SHEET with complete INSURANCE information and patient CONTACT information**
2. **Recent VISIT NOTE to support treatment (if not available in Epic)**
3. **LAB RESULTS for any required prescreening (if not available in Epic)**
4. **DIAGNOSIS CODE _____**
5. **Patient NAME and DATE OF BIRTH on EVERY page faxed**

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.

LABS:

☐ HCG QUAL, URINE, Routine, PRN, For valproate treatment in people of childbearing potential. Disregard for all others (male sex at birth, post-menopausal status, tubal ligation, hysterectomy, or bilateral oophorectomy).

NURSING ORDERS:

1. No labs needed for treatment except for women of childbearing potential to be treated with valproate. Valproate is contraindicated for prophylaxis of migraine headaches in pregnant women and in women of childbearing potential who are not using effective contraception, so pregnancy testing must be performed and negative prior to each Valproate treatment for women of childbearing potential.

MEDICATIONS:

- valproate (DEPACON) IV 1,000 mg, Intravenous (IV), ONCE, Administer over 60 minutes
- magnesium sulfate IV 2 g, Intravenous, ONCE, Administer over 60 minutes
- sodium chloride (NS) 0.9 % bolus 1,000 mL, Intravenous, ONCE, Administer over 60 minutes

PRN MEDICATIONS

☐ prochlorperazine (COMPAZINE) injection 10 mg, Intravenous, AS NEEDED for nausea

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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, 0.5 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

STAFF DIRECTIVES (as applicable):

1. Infusion staff to follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
2. Pharmacist to select appropriate admixture options including (as applicable) formulation, fluid base type, volume, concentration, administer-over time, and rate according to the package insert, drug information references, and facility policies, procedures, and practice standards.
3. Biosimilar substitutions may be permitted by infusion site policies or Collaborative Drug Therapy Management (CDTM) agreements. A pharmacist may substitute the biosimilar for authorized reasons, which may include infusion site preference or insurance reimbursement requirement. If it is NOT acceptable to substitute per site preference or insurance, check to Dispense as Written (DAW) ☐ and note the REQUIRED biosimilar: _____
4. Pharmacist may select or update orders to the site's preferred biosimilar. In addition, if insurance requires a specific biosimilar agent for reimbursement, pharmacy may update the order at sites with a Collaborative Drug Therapy Management agreement (CDTM). If it is NOT acceptable to substitute per site preference or insurance, check to Dispense as Written (DAW) ☐ and note the REQUIRED biosimilar: _____

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By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ **License #:** _____ **Date:** _____

Print Name: _____ **Phone:** _____ **Fax**:_____

Plan will expire 1 year after signature date at which time a new order will need to be placed

Contact the Referral Team directly for assistance at the centralized numbers below (do not contact individual clinics)

INFUSION REFERRAL TEAM

Fax completed orders to (503) 346-8058

Phone (providers only) (971) 262-9645

☑ **Please indicate the patient's preferred clinic location below**	
☐ **BEAVERTON** OHSU Knight Cancer Institute	15700 SW Greystone Court Beaverton OR 97006
☐ **NW PORTLAND** Legacy Good Samaritan campus	Medical Office Building 3 – Suite 150 1130 NW 22nd Ave, Portland OR 97210
☐ **GRESHAM** Legacy Mount Hood campus	Medical Office Building 3 – Suite 140 24988 SE Stark, Gresham OR 97030
☐ **TUALATIN** Legacy Meridian Park campus	Medical Office Building 2 – Suite 140 19260 SW 65th Ave, Tualatin OR 97062
☐ **Non-Legacy community providers only** **EAST PORTLAND** Adventist Health Portland campus	Pavilion – 10000 SE Main St – Suite 350 Portland, Oregon 97216

Infusion orders located at: www.ohsuknight.com/infusionorders

Referral team will consider other locations as appropriate if selected site is not available, if treatment is urgent, or for patient preference.