



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

PO7071



ADULT AMBULATORY INFUSION ORDER

Antibiotic Therapy

(Aminoglycosides, Daptomycin, & Glycopeptides)

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Page 1 of 5

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. Monitor drug levels and adjust dose as necessary.
 - a. DAPTOmycin: draw Creatine Phosphokinase (CPK) - Plasma, Weekly. Monitor CPK more frequently in patients with recent prior or concomitant therapy with an HMG-CoA reductase inhibitor, unexplained CPK increases, or renal impairment
 - b. Vancomycin: draw trough level just before the 4th dose and once weekly.
 - c. Aminoglycosides: Pharmacokinetic monitoring and dose adjustments are deferred to referring clinical team. If questions arise during the course of treatment, contact _____ (provider name) for questions via _____ (contact number)
3. Dosing weight for Aminoglycosides: based on ideal body weight (IBW) for dosing unless (1) actual body weight is less than IBW; then use actual body weight, or (2) if actual body weight is $\geq 20\%$ over IBW, then use adjusted body weight.

NURSING ORDERS:

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, dec clotting (alteplase), and/or dressing changes.
2. If gentamicin or tobramycin level lab(s) are ordered, troughs are drawn just before the dose and peaks are drawn 30 minutes after the end of the dose.
3. If amikacin level lab(s) are ordered, troughs are drawn just before the dose and peaks are drawn 30 minutes after the end of the dose. Random levels are drawn at 2 hours and 6 hours after the infusion.

Aminoglycosides:

LABS:

- CBC with auto differential, every week
- CMP, every week
- Urine Dipstick w/o micro (10 dip), every week

Amikacin for mycobacterial infection

- Random _____ level, 2 & 6 hours post-dose, every _____ (visit) (days)(weeks) (specific date) during therapy

Traditional dosing

- Peak _____ level, weekly during therapy
- Trough _____ level, weekly during therapy



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Labs already drawn. Date: _____

MEDICATION:

PROVIDER TO PHARMACIST COMMUNICATION - : Use ideal body weight (IBW) for dosing unless (1) actual body weight is less than IBW; then use actual body weight, or (2) if actual body weight is ≥ 20% over IBW, then use adjusted body weight.

- amikacin _____ mg/kg = _____ mg in sodium chloride 0.9% 100 mL IV, over 30 minutes
- gentamicin _____ mg/kg = _____ mg in sodium chloride 0.9% 100 mL IV, over 30 minutes
- tobramycin _____ mg/kg = _____ mg in sodium chloride 0.9% 100 mL IV, over 20 minutes

Interval: (must check one)

- ONCE
- Daily x _____ doses
- Every _____ days x _____ doses

DAPTOmycin:

LABS:

- CBC with differential, every _____ (visit)(days)(weeks)(months) – Circle One
- CMP, every _____ (visit)(days)(weeks)(months) – Circle One
- CK, PLASMA, ONCE prior to therapy**
- CK, PLASMA, weekly during therapy**
- Labs already drawn. Date: _____

MEDICATION:

- DAPTOmycin _____ mg/kg = _____ mg
In sodium chloride 0.9% 50 mL IV over 30 minutes, or 50 mg/mL IV push over 2-4 minutes (500 mg or less over 2 minutes, greater than 500 mg over 4 minutes) per infusion facility practice.

Interval: (must check one)

- ONCE
- Daily x _____ doses
- Every _____ days x _____ doses

Dalbavancin:

LABS:

- CBC with differential, every _____ (visit)(days)(weeks)(months) – Circle One
- CMP, every _____ (visit)(days)(weeks)(months) – Circle One
- C-reactive protein, every _____ (visit)(days)(weeks)(months) – Circle One
- Labs already drawn. Date: _____



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MEDICATION:

Single dose regimen

dalbavancin (DALVANCE) **1500 mg** in dextrose 5%, intravenous, ONCE, over 30 minutes
Interval: ONCE

Two-dose regimen

dalbavancin (DALVANCE) **1000 mg** in dextrose 5%, intravenous, ONCE, over 30 minutes
Interval: ONCE

&

dalbavancin (DALVANCE) **500 mg** in dextrose 5%, intravenous, ONCE, over 30 minutes
Interval: ONCE, 7 days after initial dose

Other

dalbavancin (DALVANCE) _____ mg in dextrose 5%, intravenous, ONCE, over 30 minutes
Interval: _____

Vancomycin:

LABS:

- CBC with differential, every _____ (visit)(days)(weeks)(months) – Circle One
- CMP, every _____ (visit)(days)(weeks)(months) – Circle One
- Vancomycin trough, weekly during therapy (first level prior to 4th dose)**
- Labs already drawn. Date: _____

MEDICATION:

- vancomycin 750 mg in sodium chloride 0.9% 150 mL IV
- vancomycin 1000 mg in sodium chloride 0.9% 250 mL IV
- vancomycin 1250 mg in sodium chloride 0.9% 250 mL IV
- vancomycin 1500 mg in sodium chloride 0.9% 300 mL IV

Infuse doses up to 1000 mg over at least 60 minutes and doses greater than 1000 mg over 120 minutes. Infusion rate not to exceed 17 mg/min

Interval: (must check one)

- ONCE
- Daily x _____ doses
- Every _____ days x _____ doses

FOR InfuSystem™ AMBULATORY PUMP USE (OHSU only; hook up at infusion location):

Duration:

- _____ days



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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

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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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

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