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

PO7071

ADULT AMBULATORY INFUSION ORDER

CIDOFOVIR (Vistide)

Infusion

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. Cidofovir IV product is restricted to order by Infectious Diseases (ID) Attending. Community orders: Send ID consult documentation.
3. Renal toxicity is a major toxicity for cidofovir. Cases of acute renal failure resulting in dialysis and/or contributing to death have occurred with as few as 1-2 doses of cidofovir. Cidofovir is contraindicated in patients who receive other nephrotoxic agents. Hydration is required with administration. Dose adjustment for changes in renal function may be required.
4. Cidofovir infusions are given in combination with probenecid. An outpatient prescription must be ordered by the referring provider and approved for patient prior to scheduling referral to infusion center. Probenecid is not supplied by ambulatory infusion clinics.
5. Renal function (serum creatinine and urine protein) must be monitored within 48 hours prior to each dose of cidofovir.
6. Cidofovir was seen to be carcinogenic, teratogenic, and cause hypospermia in animal studies.

LABS:

- ☐ Basic Metabolic Set, Routine, ONCE, every visit
- ☐ UA Dipstick without Micro (10 DIP), Routine, ONCE, every visit

NURSING ORDERS:

1. TREATMENT PARAMETER 1: Hold treatment and notify provider for serum creatinine > 1.5 mg/dL, estimated creatinine clearance ≤ 55 mL/min, or urine dipstick protein of 100 mg/dL (2+) or greater.
2. Confirm that the patient has taken probenecid prior to administration of cidofovir. Pre-treatment dose of probenecid should be 2 grams taken 3 hours prior to cidofovir infusion.
3. Remind patient to take an additional dose of 1 gram of Probenecid 8 hours after completion of the cidofovir infusion.

PRE-HYDRATION:

- Pre-hydration: sodium chloride 0.9% 1,000 mL, intravenous, ONCE, every visit, over 60 minutes, prior to cidofovir

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

MEDICATIONS:

- Cidofovir (Vistide), 100 mL of 0.9% sodium chloride, IV, ONCE, over 1 hour
  Indications (select one):
  - ❑ Acyclovir-resistant HSV infection
  - ❑ Adenovirus
  - ❑ BK virus
  - ❑ Cytomegalovirus disease
  - ❑ Other: _____

Dose (must select one):

- ❑ 3 mg/kg/dose
- ❑ 4 mg/kg/dose
- ❑ 5 mg/kg/dose
- ❑ _____

Interval (must select one):

- ❑ Once
- ❑ Once weekly x _____ doses

POST- HYDRATION

- Post-hydration: sodium chloride 0.9% 1,000 mL/hr, intravenous, ONCE, every visit, over 60 minutes, after cidofovir

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

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

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:** _____

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