OUTPATIENT PROVIDER ORDERS: Non-Hospitalized Treatment Infusion Order

COMPLETE AND FAX ORDER TO (802) 440-8205

Provider Name: _____ **Date:** _____

Provider Fax: _____ **Provider Telephone:** _____

Number of Pages: _____ **Provider Email:** _____

Comments: _____

Complete order set. **For non SVMC Practices, provide and fax the following to (802) 447-5658:**

- ☐ Clinical visit note
- ☐ Patient demographics, including insurance information
- ☐ Diagnostic lab

FORM MUST BE COMPLETE AND SIGNED BY THE PROVIDER	
Patient Name:	Phone:
DOB:	Weight (kg):
Diagnosis:	Allergies:
Admit Status: Medical Ambulatory Care	

- ☐ This is a recurring order. Any change in patient status requires a new order
- ☐ Start Date: _____ Stop Date _____ (Not to exceed 6 months)
- ☐ Procure Medication from Specialty Pharmacy
- ☐ Procure Medication from SVMC

Antibiotics	Drug	Dose	Route	Frequency	# doses
☐	Cubicin (daptomycin)	_____milligrams	IV	Every ____	
☐	Dalvance (dalbavancin)	_____milligrams	IV	Every 1 week	
☐	Invance (ertapenem)	_____milligrams	IV	Every 24 hours	
☐	Rocephin (ceftriaxone)	_____grams	IV	Every 24 hrs	
☐					

Antivirals Criteria:

- ☐ Onset of symptoms (need to start within 7 days): Date: _____
- ☐ 28 days or older and >/= to 3kg
- ☐ COVID-19 positive by PCR or Antigen Testing

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High Risk= meets one or more of the following criteria

☐ Body Mass Index >/=25 ☐ Chronic Kidney Disease ☐ Diabetes
☐ Immunosuppressive Disease ☐ Age >/=65 or < 1 yr ☐ Cardiovascular Disease
☐ Hypertension ☐ COPD or chronic respiratory disease
☐ Receiving immunosuppressive treatment.

Antivirals **Also see lab section below**	Drug	Dose	Route	Frequency	# Doses
☐ **Should not be initiated in patient with ALT**	Remdesivir (brand: Veklury)	200 mg over 1 hr	IV	Day one	1
☐ **>=10 times the upper limit of normal.**	Remdesivir	100mg over 30 min	IV	Day 2 and 3	2
Antirheumatics/TNF Blockers/Biosimilars Immunosuppressives	Drug	Dose	Route	Frequency	# Doses
☐	Actemra (tocilizumab)	_____milligrams	IV	.every ___ weeks	
☐	Avolsa (infliximab-axxq)	_____milligrams	IV	.every ___ weeks	
☐	Entyvio (vedolizumab)	300 milligrams	IV	.every ___ weeks	
☐	Fasenra (benralizumab)	30 milligrams	IV	.every ___ weeks	
☐	InFLIXimab (unbranded remicade)	_____milligrams	IV	.every ___ weeks	
☐	Inflectra (infliximab-dyyb)	_____milligrams	IV	.every ___ weeks	
☐	Ocrevus (ocrelizumab)	_____milligrams	IV	.every ___	
☐	Nulojix (Belatacept)	_____milligrams	IV	.every ___ weeks	
☐	Orencia (abatacept)	_____milligrams	IV	.every ___ weeks	
☐	Remicade (brand name infliximab)	_____milligrams	IV	.every ___ weeks	
☐	Renflexis (infliximab-abda)	_____milligrams	IV	.every ___ weeks	
☐	Rituximab (brand: Rituxan)	_____milligrams	IV	.every ___ weeks	
☐	Ruxience (bio-similar)	_____milligrams	IV	.every ___ weeks	
☐	Simponi Aria (golimumab)	_____milligrams 2mg/kg weight based dosing	IV	.every ___ weeks	
☐	Skyrizi (risankizumab-rzaa) (3 doses then	_____milligrams	IV	.every 4 weeks	3 doses

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	home injection)				
☐	Stelara (ustekinumab) (one dose then home injection)	_____milligrams	IV	ONCE	Single dose
☐	Truxima (rituximab-abbs)	_____milligrams	IV	.every ___ weeks	
☐	Xgeva (denosumab) inj.	120 milligrams	subQ	.every ___ weeks	
☐	Xolair (omalizumab)	_____milligrams	subQ	.every ___ weeks	
Iron	Drug	Dose	Route	Frequency	# Doses
☐	Feraheme	_____milligrams	IV	.every ___ weeks	
☐	Ferrlecit	_____milligrams	IV	.every ___ weeks	
☐	Injectafer	_____milligrams	IV	.every ___ weeks	
☐	Venofer	_____milligrams	IV	.every ___ weeks	
IVIG	Drug	Dose	Route	Frequency	#Doses
☐	Gammagard	_____grams	IV	.every ___ weeks	
☐	Gamunex-c	_____grams	IV	.every ___ weeks	
☐	Privigen	_____grams	IV	.every ___ weeks	
☐					
☐					
Osteoporosis	Drug	Dose	Route	Frequency	# Doses
☐	Evenity (romosozumab-aqqg) inj. [must complete lab orders on page]	210 mg/2.34 ml (105 mg/1.17 mLx2) 2 separate injections to be administered, one after the other in the abdomen, thigh, or upper arm.	SC	Q 1 month	12
☐	Prolia (denosumab) inj.	60 mg/mL	SC	X1 Q 6 months	
☐ **[must meet creatinine clearance and serum calcium level criteria prior to admin]**	Reclast (zelodronic acid) infusion **See lab ordering on pg 6**	5 mg/100 mL	IV over 20 min	X1 yearly	1

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☐	Tylenol post infusion of Reclast	650 mg	po	X1 post infusion of Reclast	1
Antineoplastics/Gonadotropin Releasing Hormone Agonist	Drug	Dose	Route	Frequency	# Doses
☐	Zoldex (goserelin acetate)	_____milligrams	subQ	.every _____ weeks	

	Pre Medications
☐	diphenhydrAMINE (Benadryl) 25 milligram orally 30 minutes prior to the infusion x1 dose
☐	diphenhydrAMINE (Benadryl) 50 milligram orally 30 minutes prior to the infusion x1 dose
☐	acetaminophen (Tylenol) 650 milligram orally 30 minutes prior to the infusion x1 dose
☐	acetaminophen (Tylenol) 1000 milligram orally 30 minutes prior to the infusion x1 dose
☐	loratadine (Claritin) 10 milligram orally 30 minutes prior to the infusion x 1 dose
☐	methylPREDNISolone (Solumedrol) _____ mg intravenously 30 minutes prior to the infusion x 1 dose
☐	EMLA Cream 1 application topically 30 minutes prior to the infusion x1 dose
☐	

Saline flush for central lines

✔	Saline Flush flush with 10 mL Saline after infusion to port per protocol.

IV Fluids

☐	Normal Saline 250 milliliter 125 ml/hr intravenously x 1 bag to run concurrently with ordered infusion

IV Bolus Fluids

☑	Normal Saline 250 milliliter bolus 999 ml/hr as needed for hypotension (SBP greater than or equal to 95 mmHg) or symptomatic

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	Contingency Medications (PRN)
☐	acetaminophen (Tylenol) 1,000 milligram orally as needed x 1 dose for fever
☐	diphenhydrAMINE (Benadryl) 25 milligram orally as needed for signs and symptoms of allergic reaction
☐	loratadine (Claritin) 10 milligram orally as needed x1 dose for signs of allergic reaction
☐	Solumedrol ____ milligram intravenously as needed x1 dose for signs of allergic reaction
☐	Cathflo [Alteplase] 1 ML intravenously as needed instill one dose for restoration of central venous access device, may repeat x1 after 2 hours.

MONITORING

- ✔ Access Port-a-cath or PICC if applicable.
- ✔ Insert peripheral line if needed.
- ✔ Obtain vital signs prior to administration
- ✔ Monitor vital signs per delivery of care policy for medical ambulatory and infusion services.
- ✔ If signs and symptoms of a clinically significant hypersensitivity reaction or anaphylaxis occur, immediately discontinue administration and initiate appropriate medications and/or supportive therapy (see ADVERSE REACTIONS below)

ADVERSE REACTIONS	
MINOR REACTIONS (e.g. nausea, itching, joint pain, rash)	**SEVERE REACTIONS** (e.g. bronchospasm, loss of airway, fainting, severe flushing)
STOP infusion	**CALL A CODE or RAPID RESPONSE**
DiphenhydrAMINE 50 mg **IV Push** Once	**STOP** infusion
Famotidine 20 mg IV Push Once	EPINEPHrine 0.3 mg/o.3 ml Subcutaneous Once
dexamethasone 10 mg IV Push Once	**Oxygen PRN**
Notify Provider	Notify Provider

Additional Orders

☐ Diet Regular as tolerated ☐ Other: _____

☐ Code status: Full Code ☐ Other: _____

☐ Activity as tolerated ☐ Other: _____

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Labs

- ☐ CBC + Platelets (NO Diff) - Frequency: _____
- ☐ CBC + Platelets + Diff (Elec) - Frequency: _____
- ☐ Comp Metabolic Panel - Frequency: _____
- ☐ ESR Sedimentation Rate - Frequency: _____
- ☐ CRP Quant, Non-Cardiac - Frequency: _____
- ☐ Envity: Vitamin D-25 Hydroxy D2 + D3 [TO BE DRAWN AFTER 5TH DOSE OF ENVITY]
- ☐ Envity: Calcium Level; Ca++ [TO BE DRAWN AFTER 5TH DOSE OF ENVITY] Reclast:
- ☐ Creatinine Clearance prior to administration
- ☐ Reclast: Calcium Level prior to administration
- ☐ Remdesivir: Liver enzymes (must be drawn within 60 days prior to administration
- ☐ Remdesivir: Liver enzymes prior to 3rd dose
- ☐ Immunoglobulin panel
- ☐ Other orders: _____

☐ Discharge to home after medication administration with appropriate discharge instructions.

Provider Signature: _____ Date: _____ Time: _____

Printed Name: _____