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INFUSION ORDERS: belimumab (Benlysta)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

Premedicate:

- ❑ Acetaminophen 1,000 mg PO prior to infusion
- ❑ Diphenhydramine 25 mg PO prior to infusion

  OR
- ❑ Diphenhydramine 25 mg IV prior to infusion
- ❑ Methylprednisolone 125 mg IV push over 3 - 5 minutes prior to infusion

If 1st dose observe patient for 30 minutes after infusion to verify no reaction.

belimumab dose:

- ❑ 10 mg/kg IV every 2 weeks X 3 doses, then every 4 weeks, infuse over 1 hour.
- ❑ 10 mg/kg IV every 4 weeks, infuse over 1 hour.

PPD/Quantiferon Gold Results:_____ Date:_____

Chest Xray:_____

Lab work: _____

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

belimumab (Benlysta) Infusion Orders

ORD.PHY

Adult (page 1)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

Adverse reaction protocol:

For urticaria, pruritus, or shortness of breath give:
Diphenhydramine 25 mg IV, if IV unavailable may give 25 mg PO.
If Diphenhydramine ineffective after 15 minutes may repeat
Diphenhydramine 25 mg IV, if IV unavailable may give 25 mg PO.
If symptoms persist give Methylprednisolone 125 mg IV up to every 4 hours PRN until symptom resolution.

Acetaminophen 500 mg PO every 4 hours PRN for aches, or temperature increase greater than 2 degrees F. **DO NOT EXCEED 4 GRAMS IN 24 HOURS.**

For chest pain or dyspnea give oxygen by nasal cannula at 2.5 liters/minute.

For Anaphylaxis (Severe respiratory distress, reduced blood pressure, other life threatening symptoms)

Notify provider and call 911

Epinephrine: (1 mg/mL) 0.5 mg IM every 5 minutes PRN for anaphylaxis.
If no response dose may be repeated every 5 minutes until anaphylaxis resolves.

Do not repeat if patient develops arrhythmia, ventricular fibrillation, rapid rise in blood pressure or palpitations.

Racemic epinephrine 2.25% 0.5 mL/11.25 mg via nebulizer PRN for stridor only.

See reverse side for Pediatric Protocol ⇨

Pediatric (page 2)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

Adverse reaction protocol:

Acetaminophen 10 mg/kg PO every 4 hours PRN for aches or temperatures increase greater than 2 degrees F. (Max 500 mg/dose and 75 mg/kg day, or 4,000 mg whatever is lowest). May have liquid or tablet.

For uticaria, pruritis and shortness of breath:

Diphenhydramine 1 mg/kg IV every 4 hours prn uticaria or pruritis (Max 25 mg per dose), if IV unavailable may give Diphenhydramine 1 mg/kg PO every 4 hours prn uticaria or pruritis (Max 25 mg per dose). May have liquid or tablet.

OR

Cetirizine 5 mg PO once for patients under 6 years old, 10 mg for patients 6 years and older. (There is not weight based dosing for this drug). May have liquid or tablet.

If patient develops shortness of breath, or if urticaria or pruritis are severe or rapidly progressing after antihistamine give:

Methylprednisolone 1 mg/kg x 1 IV (max 125 mg).

Racemic epinephrine 2.25% via nebulizer PRN stridor.

If symptoms progress despite above treatment or patient develops anaphylaxis (severe respiratory distress, reduced blood pressure, or other life threatening symptoms). Call 911 and medical provider.

Epinephrine 0.01 mg/kg every 5 minutes IM as needed for anaphylaxis for a max of 3 dose. Max dose is 0.5 mg.

Oxygen via nasal cannula/mask to maintain oxygen saturation greater than 90%

Age 18+ see adult protocol

INJECTION ORDERS: certolizumab (Cimzia)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

certolizumab dose:

- ❑ 400 mg subcutaneously every 4 weeks
- ❑ 400 mg subcutaneously every 2 weeks X 3, then every 4 weeks

If 1st dose observe patient for 30 minutes after injection to verify no reaction.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____

Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Cimzia (Certolizumab) Injection Orders

ORD.PHY

PO500-026-N-1 (3-19)

INJECTIONS ORDERS: benralizumab (Fasenra)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

benralizumab dose:

- ❑ 30 mg subcutaneously every 8 weeks
- ❑ 30 mg subcutaneously every 4 weeks, X 3, then every 8 weeks

If 1st dose observe patient for 30 minutes after injection to verify no reaction.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____

Time: _____

PATIENT IDENTIFICATION:

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2550 Broadway • Helena, MT 59601 (406) 495-6852

benralizumab (Fasenra) Injection Orders

ORD.PHY

INFUSION ORDERS: Ibandronate (Boniva)

Name:_____ DOB:_____

Medication Allergies:_____

Ht:_____inches Wt:_____kg

Diagnosis:_____

Ibandronate Dose:

❑ 3 mg/3 mL IV every 3 months, to be given IV push over 1 - 3 minutes.

*Have you had any recent major dental work or extractions?
(If yes notify physician)

If 1st dose observe patient for 30 minutes after infusion to verify no reaction.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name:_____

Provider Signature:_____

Date:_____

Time:_____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
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Ibandronate (Boniva) Infusion Orders

ORD.PHY

INFUSION ORDERS: tocilizumab (Actemra)

Name:_____ DOB:_____

Medication Allergies:_____

Ht:_____ inches Wt:_____ kg

Diagnosis:_____

tocilizumab dose:

- ❑ 4 mg/kg IV 1st dose, infuse over one hour
- ❑ 8 mg/kg IV every 4 weeks **NOT TO EXCEED 800 MG PER DOSE**, over one hour
- ❑ Other:_____

PPD/Quantiferon Gold Results:_____ Date:_____

Chest X-ray:_____

Lab work: CBC with auto diff and CMP at 4 weeks then every 12 weeks
Fasting lipids at 4 weeks, then every year

If 1st dose observe patient for 30 minutes after infusion to verify no reaction.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name:_____

Provider Signature:_____

Date:_____

Time:_____

Patient Identification:

St. Peter's Health Infusion Center
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Tocilizumab (Actemra) Infusion Orders

ORD.PHY

GENERAL ORDERS: CRH Stimulation Test (Endocrinology Only)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

Medications needed: corticorelin ovine triflutate (Acthrel for injection) 100 mcg and NS 2 mL for reconstitution

CRH/CRH Stimulation Test:

- ❑ Patient is to fast for 4 hours or more
- ❑ No steroids to be taken the day before or the day of the test

1. Establish intravenous access line. Draw a baseline ACTH and Cortisol level
2. Give synthetic ovine CRH (1 mcg per kg body weight or 100 mcg total dose) as injected as an intravenous bolus over 30-60 seconds
3. Draw ACTH and Cortisol Level at 30 minutes, 60 minutes and 90 minutes from CRH administration
4. Additional labs desired: _____
5. Some patients may have mild, brief facial flushing immediately after injection, but there are no other side effects at this dose level. Allergic reactions have not been reported.

Provider Printed Name: _____

Provider Signature: _____

Date: _____

Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

CRH Stimulation Test (Endocrinology Only)

PO500-036-N-1 (3-19)

PROTOCOL: Clonidine/Arginine Stimulation for Growth Hormone Deficiency in Children

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

Medications required:

Clonidine (PO) 0.15 mg/m^2 as a single dose. You can use http://www.globalrph.com/bsa2.htm to calculate body surface area in m^2

Side effects: postural hypotension and tiredness. Patient should be seated during the entire test. Ask them to use the restroom before starting. If they must get up to use the restroom during the test they must be accompanied to the toilet. Risk of dizziness due to postural hypotension is moderate to high.

Arginine HCL (IV) 0.5 g/kg (max 30 grams) 10% arginine HCl in 0.9% NS infused over 30 minutes
Side effects include nausea

Patient must adhere to an overnight fast before testing and must have a documented normal TSH before testing continues.

1. Patient to be seated and calm
2. Check BP
3. Place IV and draw baseline GH level
4. Dose the patient with the oral clonidine
5. Start arginine infusion
   a. The end of the infusion is time zero
6. Draw growth hormone levels at 15, 30, 45, 60 and 90 minutes
7. After last blood draw check blood pressure and walk patient around to check for posteral hypotension. Parent or caregiver can take patient home if blood pressure is at baseline and the patient is not symptomatic. Patient must leave clinic in a wheelchair. Caregiver is encouraged to push fluids the remainder of the day.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

PROTOCOL: Clonidine/Arginine Stimulation for Growth Hormone Deficiency in Children

ORD.PHY

INFUSION ORDERS: vedolizumab (Entyvio)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

Labs: _____

Premedications:

❑ _____

vedolizumab dose:

❑ 300 mg IV over 30 minutes on weeks 0, 2, 6, then every 8 weeks.

***Must be flushed with 30 mL of NS post infusion.**

If 1st dose observe patient for 30 minutes after injection to verify no reaction.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____

Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Entyvio (Vedolizumab) Infusion Orders

ORD.PHY

PROTOCOL: Fasting Hypoglycemia

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

Allow 8 full hours for the test. Schedule when provider will be in the office.

Purpose:

The purpose of this evaluation is to assist in determining the etiology of hypoglycemia in a patient. Its primary focus is to identify patients with insulinoma and thus patients should have a full pre-protocol workup for other causes of hypoglycemia before starting this protocol.

The time at which the patient begins their fast should be determined by the physician. The longer the patient can fast the better the overall sensitivity of the test. Patients should be fasted at least 8 hours and 24 hours at a minimum. This will often times require the patient to be fasting at home the night before. The ordering physician should determine if it is safe for the patient to fast overnight before the test begins and if it is safe for the patient to drive themselves to the clinic for testing.

Medication needed from pharmacy:

500 mL NS 100 mL/hour as needed
500 mL D-5W 100 mL/hour as needed for symptomatic documented low glucose less than 60 mg/dL
Glucagon 1 mg for IV push
D-50W IV push STAT for the unresponsive patient

Per provider, all glucose samples need to be drawn in a **grey top tube**, they have an additive that stabilizes the glucose level in the tube.
(If it is accidentally drawn in an SST, like the mobi lab tells us to draw it, it has to be run STAT!)

1. Patient is to be seated while starting IV.
2. Have D-5W hanging and ready to use if needed.
3. Draw base line glucose in a **grey top tube** and baseline cortisol, growth hormone, C-peptide, insulin level, proinsulin and beta-hydroxybuterate levels. Also collect sulfonylurea screen (urine).
    a. Send the glucose and the sulfonylurea screen to be spun and processed. Date, time and save the remainder tubes without running the samples. Take the remaining tubes to the lab and put a note on the bag to hold and spin all tubes (these need to be spun and frozen immediately to be accurate).

Continued >

PROTOCOL: Fasting Hypoglycemia

(Continued from page 1)

4. Check blood sugars every 2 hours until patient begins having symptoms or blood sugars drop to less than 60 mg/dL.
   a. When patient begins having symptoms redraw cortisol, growth hormone, C-peptide, insulin level, proinsulin and beta-hydroxybuterate levels, date and time them and put them on hold.
5. When blood sugars drop below 60 mg/dL or the patient begins to have symptoms then check blood sugars every 30 min to 1 hour.
6. Monitor patient closely after this documenting types of symptoms.
7. If and when blood sugars reach <45 mg/dL draw glucose, cortisol, growth hormone, C-peptide, insulin level, proinsulin and beta-hydroxybuterate levels, date time and hold.
8. The test is completed when
   a. The patient reaches a blood sugars of <45 mg/dL with or without symptoms.
   b. The blood sugars are >45 mg/dL and <55 mg/dL but the patient has symptoms.
   c. If the patient has significant symptoms but the blood sugars is not below 55 mg/dL then notify the ordering provider for instructions.
   d. If 8 hours have passed, the patient has been asymptomatic, and the blood glucose has remained above 60 mg/dL, the patient may be discharged and no further labs are needed. Check with provider prior to discharge.
9. After determining that the test is complete the following steps are then taken
   a. Redraw glucose, cortisol, growth hormone, C-peptide, insulin level, proinsulin and beta-hydroxybuterate levels, date and time the samples and send to lab.
   b. Ask the ordering provider if any of the above sample should be sent.
   c. Give the patient 1 mg of glucagon IV and reset time to zero.
   d. Draw glucose at 10, 20 and 30 minutes following the glucagon.
   e. Feed the patient with complex carbs and juice and monitor for 30 minutes before discharge.
10. The patient who undergoes a fast can have reactive low blood sugars after feeding so the monitoring is important. Ask them to eat when they go home and be aware that after eating, their glucose will drop. Make sure they have food on hand and juice and should have a driver to take them home.
11. **LAB ORDERING:**
    a. Cortisol is under CORT, Human growth hormone is under HGH, C-peptide is under CPep, Glucose is under GLU, Insulin is under INS, Proinsulin is under Pro-I, beta-hydroxybuterate is in system under B-OH, Sulfonylurea screen is entered under MISC with ARUP reference 0091100 Hypoglycemic Panel. Per ARUP, urine is the preferred specimen.

Provider Printed Name: _____

Provider Signature: _____

Date: _____

Time: _____

PATIENT IDENTIFICATION:

GENERAL ORDERS: OUTPATIENT

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

Site where patient will receive Administration (check/specify):

❑ Infusion Center:

❑ Other: _____

❑ Routine PICC Care

❑ Port maintenance-flush with 10 mL NS

❑ Port maintenance with 10 mL NS and 5 mL 100u/mL Heparin

Routine Labs to be done (check):

❑ CBC PLT w/Autodiff ❑ Full Chemistry ❑ CRP ❑ Procalcitonin

❑ Other (name): _____

Frequency of laboratory tests every (check):

❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday

❑ Lab draw interval: _____

❑ **Premedication(s):** _____ (if any)

❑ **Medication(s) Dose:** _____

Duration: _____ Estimated End of Therapy through: _____

❑ Results to (Provider): _____

❑ Follow up Appointments (Provider): _____

❑ Please fax these orders to:_____ (fax directly to them)

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

GENERAL ORDERS: OUTPATIENT

ORD.PHY

GENERAL ORDERS: Human Growth Hormone Testing

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

Medications: Levodopa 500 mg PO (given at start of Arginine infusion)
Arginine 30 gram IV infusion over 30 minutes (patient to be seated for at least 30 minutes prior to starting)

Labs: Human growth hormone to be drawn at -30, 30, 60, 90, 120, 150 minutes drawn from opposite arm, may place additional IV to do all labs from

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Human Growth Hormone Testing

ORD.PHY

GENERAL ORDERS: Hydration

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

ORDER: _____Liter(s) ❑ **NS or** ❑ **LR** (check one) IV to be given

❑ ____999 mL/hr

or

❑ _____ mL/hr

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

GENERAL ORDERS: **Hydration**

ORD.PHY

INFUSION ORDERS: immunoglobulin Intravenous (IVIG)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

Premedicate:

- ❑ Acetaminophen 1,000 mg PO 30 minutes prior to infusion
- ❑ Diphenhydramine 25 mg PO 30 minutes prior to infusion
- ❑ Diphenhydramine 25 mg IV 30 minutes prior to infusion

immunoglobulin intravenous dose:_____Mg/Kg_____

Frequency:_____

If 1st dose observe patient for 30 minutes after infusion to verify no reaction.

Initial infusion:

Initiate at 0.3 mL/kg/hr
after 15 minutes 0.5 mL/kg/hr
after 30 minutes 1.0 mL/kg/hr
after 30 minutes 2.4 mL/kg/hr

Subsequent infusions:

Initiate at 0.3 mL/kg/hr
after 15 minutes 1.0 mL/kg/hr
after 30 minutes 2.0 mL/kg/hr
after 30 minutes 4.8 mL/kg/hr
MAX rate is 8 mL/kg/hr

***Monitor vital signs every 30 minutes while infusion is running**

Labs:_____

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Immunoglobulin Intravenous (IVIG)

ORD.PHY

PO500-043-N-1 (3-19)

INFUSION ORDERS: infliximab (Inflectra)

Diagnosis: _____

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

PPD/Quantiferon Gold: _____ Date:_____

Results:_____

Pre-medicate before first infusion or all infusions (please check);

- ❑ Acetaminophen 1,000 mg PO
- ❑ Diphenhydramine 25 mg PO
- ❑ Diphenhydramine 25 mg IV
- ❑ Methylprednisolone 125 mg IV
- ❑ Other:_____

infliximab dose/administration:

infliximab _____mg/kg, (TOTAL mg will be rounded up to nearest 100 mg) to be infused over at least 2 hours.

For first infusion initiate at 10 mL/hr
after 15 minutes increase to 20 mL/hour
after 15 minutes increase to 40 mL/hour
after 15 minutes increase to 80 mL/hour
after 15 minutes increase to 250 mL/hour for the remainder of the infusion.

For subsequent infusions (if there was no infusion reaction with the first infusion) titrate as follows:
100 mL/hr for 10 minutes
200 mL/hr for 10 minutes
300 mL/hr for remainder of infusion

Visit Frequency: Three visits: Day 0, 2 weeks after initial visit and 6 weeks after initial visit followed by infusions every 8 weeks thereafter or_____ weeks.

Continued >

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
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INFUSION ORDERS: infliximab (Inflectra)

(Continued from page 1)

Name:_____ DOB:_____

Lab work:

- ❑ CBC with auto-diff
- ❑ CMP
- ❑ PPD
- ❑ Other: _____

Frequency of lab draws: _____

Diagnosis: _____

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Infliximab (Inflectra) Infusion Orders

ORD.PHY

INFUSION ORDERS: ferric carboxymaltose (Injectafer)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

ferric carboxymaltose dose:

- ❑ 750 mg given IV X _____dose(s) 7 days apart, infuse over a minimum of 15 minutes.

  Or

- ❑ 15 mg/kg if under 110 lbs IV X _____dose(s) 7 days apart, infuse over a minimum of 15 minutes.

If 1st dose observe patient for 30 minutes after injection to verify no reaction.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Ferric Carboxymaltose (Injectafer) Infusion Orders

ORD.PHY

INFUSION ORDERS: alemtuzumab (Lemtrada)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

Pre-medications:

❑ Methylprednisolone 1,000 mg in 100 mL 0.9% Sodium Chloride IV infusion via pump over 60 minutes daily for the first 3 days of each treatment course.

❑ Acetaminophen 1,000 mg PO to prevent fever and headache

❑ Diphenhydramine 50 mg PO to prevent itching/hives

alemtuzumab dose:

❑ Year One: Lemtrada® 12 mg in 100 mL 0.9% Sodium Chloride IV infusion via pump over 4 hours daily for 5 days. Protect from light. (may extend duration if needed)

❑ Year Two: Lemtrada® 12 mg in 100 mL 0.9% Sodium Chloride IV infusion via pump over 4 hours daily for 3 days. Protect from light. (may extend duration if needed)

Patient must be monitored for 2 hours post infusion.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Alemtuzumab (Lemtrada) Infusion Orders

ORD.PHY

INJECTION ORDERS: mepolizumab (Nucala)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

mepolizumab dose:

- ❑ 100 mg SQ injection every 4 weeks
- ❑ 300 mg SQ injection every 4 weeks (Eosinophilic granulomatosis with polyangitis only, administered as three injections at least 2 inches apart.)

Observe patient for 30 minutes after first injection only.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Mepolizumab (Nucala) Injection Orders

PO500-047-N-1 (3-19)

INFUSION ORDERS: belatacept (Nulojix)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

Premedications:_____

belatacept dose:

- ❑ 10 mg/kg IV every 4 weeks _____
- ❑ 5 mg/kg IV every 4 weeks _____

If 1st dose observe patient for 30 minutes after infusion to verify no reaction.

Labs:_____

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Belatacept (Nulojix) Infusion Orders

ORD.PHY

INFUSION ORDERS: ocrelizumab (Ocrevus)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

Hep B screen: _____

Pre-medications: 30 minutes prior to Ocrevus infusion:

- Methylprednisolone 125 mg IV push, depending on pharmacy availability.
- Acetaminophen 1,000 mg PO
- Diphenhydramine 25 mg PO
  OR
- Diphenhydramine 25 mg IV

ocrelizumab dose:

❑ Initial dosing:
Initial dose of 300 mg/250 mL IV followed by a second dose of 300 mg/250 mL 2 weeks later followed by maintenance dosing. Start at a rate of 30mL/hour. Thereafter, increase the rate by 30 mL/hour every thirty minutes to a maximum of 180 mL/hour. Each infusion will last 2.5 hours or longer.

After the first two infusions have been completed, start at a rate of 40 mL/hour.

❑ Maintenance dosing: 600 mg/500 mL IV every 6 months start at a rate of 40 mL/hour. Thereafter, increase the rate by 40 mL/hour every 30 minutes to a maximum of 200 mL/hour. Each infusion will last 3.5 hours or longer.

Observe the patient for 60 minutes after each infusion to verify no reaction.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

ocrelizumab (Ocrevus) Infusion Orders

ORD.PHY

PO500-049-N-1 (3-19)

INFUSION ORDERS: abatacept (Orencia)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

abatacept dose:

- ❑ 500 mg IV for patient weight less than 60 kg/132 pounds
- ❑ 750 mg IV for patient weight 60 - 100 kg/132 - 220 pounds
- ❑ 1,000 mg IV for patient weight greater than 100 kg/220 pounds

Frequency: Every 2 weeks x 3 doses, then every 4 weeks

❑ Physician check this box to acknowledge **dose does not correspond** to patient's weight.

Lab work:_____

If 1st dose observe patient for 30 minutes after infusion to verify no reaction.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Abatacept (Orencia) Infusion Orders

ORD.PHY

General Orders: Outpatient Antibiotics

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

Site where patient will receive Administration (check/specify):

❑ Infusion Center:_____

❑ Other:_____

❑ Routine PICC Care

❑ Port maintenance-flush with 10 mL NS

❑ Port maintenance-flush with 10 mL NS and 5 mL 100u/mL Heparin

❑ Peripheral IV start and maintenance

Routine Labs to be done while on antibiotics (check):

❑ CBC PLT w/Autodiff ❑ Full Chemistry ❑ CRP ❑ Procalcitonin

❑ Other (name): _____

Frequency of laboratory tests every (check):

❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday

❑ Lab draw interval:_____

❑ **Premedication(s)**:_____(if any)

❑ **Medication(s)** Dose: _____

Duration:_____ Estimated End of Therapy through: _____

❑ Results to (Provider):_____

❑ Follow up Appointments (Provider):_____

❑ Please fax these orders to:_____(fax directly to them)

Provider Sign: _____ Date:_____Time:_____

Provider Print:_____

PATIENT IDENTIFICATION:

St. Peter's Health

2475 Broadway • Helena, MT 59601 (406) 442-2480

General Orders: Outpatient Antibiotics

ORD.PHY

PO500-051-N-1 (3-19)

PHLEBOTOMY ORDER

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

ORDER:

- ❑ Draw a HCT and Hgb (results must be within 7 days of scheduled phlebotomy appointment and Hgb must be at least 12 for phlebotomy to be completed.)
- ❑ Goal HCT_____ and/or Hgb_____(only need for a diagnosis of Polycythemia Vera).
- ❑ Draw a serum Ferritin for those with a diagnosis of Hemochromatosis.
- ❑ Goal serum Ferritin of 50 ng/mL or _____ng/mL.
- ❑ Phlebotomize one unit (500 mL) or _____mL monthly or weekly until labs are at goal.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Phlebotomy Order

ORD.PHY

PO500-053-N-1 (3-19)

FLUSH ORDERS: Port-A-Cath Flush Orders

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: Port Maintenance

Flush port-a cath monthly with (please indicate):

- ❑ 10 mL NS flush
- ❑ 10 mL NS flush followed by Heparin 5 mL 100 u/mL flush.

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Port-Cath-Flush Orders

ORD.PHY

PO500-054-N-1 (3-19)

INJECTION ORDERS: denosumab (Prolia)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

denosumab dose:

60 mg subcutaneously every 6 months

If 1st dose observe patient for 30 minutes after injection to verify no reaction.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Denosumab (Prolia) Injection Orders

ORD.PHY

INFUSION ORDERS: zoledronic acid (Reclast)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

zoledronic acid dose:

5 mg IV in 100 mL in one dose per year. To be infused over 20 minutes.

*****Have you had any recent major dental work or extractions?
(If yes notify physician)

If 1st dose observe patient for 30 minutes after infusion to verify no reaction.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Zoledronic Acid (Reclast) Infusion Orders

ORD.PHY

INFUSION ORDERS: rituximab (Rituxan)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

PPD: Date:_____ Results:_____

Instruct patient to HOLD antihypertensive medication 12 hours prior to administration.

Pre-medicate before first infusion or all infusions (check one);

- ❑ Acetaminophen 1,000 mg PO
- ❑ Diphenhydramine 25 mg PO
- ❑ Diphenhydramine 25 mg IV
- ❑ Methylprednisolone 125 mg IV
- ❑ Other:_____

rituximab dose:

- ❑ Regimen 1: 375 mg/M^2 IV (dilute in 250 mL 0.9% sodium chloride) infusion once a week x 4 weeks
- ❑ Regimen 2: initial dose of 1,000 mg (dilute in 250 mL 0.9% sodium chloride, Maximum final concentration is 4 mg/mL) IV infusion followed by a second dose of 1,000 mg IV infusion two weeks later, repeat every 6 months
- ❑ Regimen 3: 500 mg IV every 6 months.
- ❑ Other:_____

Administration:

First infusion (day one) begin at 50 mg/hour and then increasing the infusion rate by 50 mg/hour every thirty minutes up to a max of 400 mg/hour.

The second infusion on Day 15 and subsequent infusions (if the patient did not experience an infusion reaction with the previous reaction) begins at 100 mg/hour and increasing the rate by 100 mg/hour every thirty minutes up to a max of 400 mg/hour.

Continued >

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Rituximab (Rituxan) Infusion Orders

ORD.PHY

INFUSION ORDERS: rituximab (Rituxan)

(Continued from page 1)

Lab work:

- ❑ CBC with auto-diff
- ❑ CMP
- ❑ PPD
- ❑ Other:_____

Frequency of lab draws: _____

Diagnosis:

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Rituximab (Rituxan) Infusion Orders

ORD.PHY

INFUSION ORDERS: golimumab (Simponi Aria)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

golimumab dose:

❑ 2 mg/kg IV over 30 minutes on weeks 0, 4 weeks, then every 8 weeks

PPD/Quantiferon Gold Results:_____ Date:_____

Chest X-ray:_____

Lab work: CBC with auto diff and CMP every infusion.

If 1st dose observe patient for 30 minutes after infusion to verify no reaction.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Golimumab (Simponi Aria) Infusion Orders

ORD.PHY

INFUSION ORDERS: methylprednisolone (Solumedrol)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

methylprednisolone dose:
_____IV_ X_____ days, infused over one hour

If 1st dose observe patient for 30 minutes after infusion to verify no reaction.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Methylprednisolone (Solumedrol) Infusion Orders

ORD.PHY

PO500-059-N-1 (4-19)

INFUSION ORDERS: ustekinumab (Stelara)

Name:_____ DOB: _____

Medication Allergies: _____

Height: _____ inches Weight: _____ kg

Diagnosis: _____

For Crohn's Disease:

ustekinumab initial dose is IV

IV: Use 0.22 micron filter, do not infuse concomitantly in same IV line with other agents.

- ❑ Weight 55 kg or less
  Dose is 260 mg IV infuse over one hour x 1
- ❑ Weight more than 55 kg to 85 kg
  Dose is 390 mg IV infuse over one hour x 1
- ❑ Weight more than 85 kg
  Dose is 520 mg IV infuse over one hour x 1

Initial dose given on_____(Date). All doses after are Maintenance.

Maintenance dose is given subcutaneously:
ustekinumab 90 mg every 8 weeks, begin maintenance dosing 8 weeks after the IV induction dose.

For Plaque Psoriasis:
ustekinumab initial and maintenance dose is subcutaneous

- ❑ Weight less than or equal to 100 kg
  Dose is 45 mg subcutaneously initially and four weeks later, followed by 45 mg subcutaneously every 12 weeks.
- ❑ Weight greater than 100 kg
  90 mg subcutaneously initially and four weeks later, followed by 90 mg subcutaneously every 12 weeks.

Continued on page 2 >

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Ustekinumab (Stelara) Infusion Orders

ORD.PHY

PO500-060-N-1 (9-19)

INFUSION ORDERS: ustekinumab (Stelara)

(Continued from page 1)

For Psoriatic Arthritis:

ustekinumab

❑ Dose is 45 mg subcutaneously initially and four weeks later, followed by 45 mg subcutaneously every 12 weeks.

❑ For patients with co-existent moderate-to-severe plaque psoriasis weighing greater than 100 kg the dose is 90 mg subcutaneously initially and four weeks later, followed by 90 mg subcutaneously every 12 weeks

If 1st dose observe patient for 30 minutes after injection to verify no reaction.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

INFUSION ORDERS: natalizumab (Tysabri)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

Premedicate:

- ❑ Acetaminophen 1,000 mg PO prior to infusion
- ❑ Diphenhydramine 25 mg PO prior to infusion
- ❑ Diphenhydramine 25 mg IV prior to infusion

natalizumab dose:

300 mg IV every 4 weeks to be infused over 1 hour.

If 1st dose observe patient for 30 minutes after infusion to verify no reaction.

Lab work:_____

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Natalizumab (Tysabri) Infusion Orders

ORD.PHY

GENERAL ORDERS: Water Restriction Test

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

Schedule on a day that provider will be in the office.

The water restriction test is used to differentiate the possible causes of polyuria in the non-diabetic patient specifically looking for the diagnosis of diabetes insipidus (central vs nephrogenic).

If the patient being tested is known to have diabetes mellitus it is essential that the patient's blood sugars are within reasonable control before proceeding with test. This can be determined with a finger stick blood glucose if the patient is diabetic, a reading under 200 mg/dL is considered reasonable.

Medication needed:

1. Desmopressin:
   - ❑ 10 mcg by nasal insufflation
   - ❑ 4 mcg subcutaneously
   - ❑ 4 mcg intravenously
2. Normal saline-volume and rate to be determined by provider if needed during the test.

Risks:

1. Hypernatremia
2. Hypotension and dehydration

The patient should stop drinking two to three hours before coming to the office or clinic; overnight fluid restriction should be **avoided,** since potentially severe volume depletion and hypernatremia can be induced in patients with marked polyuria. Some patients cannot keep from drinking for 3 hours either due to severe thirst or the psychological withdrawal response to water.

Patient must be monitored closely and be where they can be seen at all times. Some classes of patients with polyuria will do very unusual things to get a drink of water.

Continued >

GENERAL ORDERS: Water Restriction Test

(Continued from page 1)

Initiation:

Measurement of the urine volume (using a hat) and osmolality (OSMOU, clear tube in urine collection kit) every hour and the serum sodium concentration (NA, SST tube) and osmolality (OSMO, SST tube) **every two** hours.

The water restriction test is continued until one of the following end points is reached:

1. The urine osmolality reaches a clearly normal value (above 600 mosmol/kg), indicating that both ADH release and effect are intact. Patients with partial DI may have a substantial rise in urine osmolality, but not to this extent.
2. The urine osmolality is stable on two or three successive hourly measurements despite a rising plasma osmolality. Provider will determine if osmolality is stable.
3. The plasma osmolality exceeds 295 to 300 mosmol/kg or the plasma sodium is 145 meq/L or higher.

If either #2 or #3 above occur then give desmopressin:

- ❑ 10 mcg by nasal insufflation
- ❑ 4 mcg subcutaneously
- ❑ 4 mcg intravenously

After desmopressin given measure urine osmolality and volume should be measure every 30 minutes for the following 2 hours.

At the conclusion of the 2 hours post desmopressin draw a serum sodium level (NA, SST tube) and the patient is allowed full access to water. If the serum sodium is normal (136-145) then the patient may be discharged by nurse. If the sodium is not normal then the ordering provider or the covering provider must approve discharge.

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

INFUSION ORDERS: omalizumab (Xolair)

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

omalizumab dose:

_____ (75 - 375) mg subcutaneously every_____(2 - 4)weeks

Observe patient for 2 hours post injection X 3, then 30 minutes after each subsequent injection.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Omalizumab (Xolair) Infusion Orders

ORD.PHY

GENERAL ORDERS: Mixed Meal Testing Orders

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

❑ **Labs Per Mixed Meal Test Protocol**

Medications Needed From Pharmacy:

500 mL NS 100 mL/hour IV as needed
500 mL D-5W 100 mL/hour IV as needed for symptomatic documented low glucose less than 60 mg/dL
Glucagon 1 mg for IV Push as needed for unresponsive patient
D-50W 1 ampule IV push STAT for unresponsive patient

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Mixed Meal Testing Orders

ORD.PHY

PO500-064-N-1 (4-19)

GENERAL ORDERS: Romosozumab (Evenity) Subcutaneous Injection

Name:_____ DOB: _____

Medication Allergies: _____

Ht: _____ inches Wt: _____ kg

Diagnosis: _____

❑ Confirm patient has not had a myocardial infarction (MI) or stroke within the preceding year. Consider benefits/risks of therapy in patients with other cardiovascular risk factors. If patient experiences myocardial infarction or stroke during therapy, Evenity should be discontinued.

❑ Confirm patient is taking supplemental calcium (500 mg to 1000 mg daily) and vitamin D (600 to 800 units daily).

❑ **Romosozumab Dose:** Two prefilled syringes, administered at two separate subcutaneous sites are needed to administer the total dose of 210 mg of Evenity. Inject two 105 mg/1.17 mL prefilled syringes, one after the other. Treatment duration is 12 monthly doses.

No pre-medications needed

Lab work: Provider choice, no routine labs recommended.

❑ **Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)**

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

PATIENT IDENTIFICATION:

St. Peter's Health Infusion Center
2550 Broadway • Helena, MT 59601 (406) 495-6852

Romosozumab (Evenity) Subcutaneous Injection

ORD.PHY