Antibiotic Therapy

(Aminoglycosides, Daptomycin, & Glycopeptides)

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. 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: For daily dosing, draw random level 12 hours after the start of infusion and once weekly. For every 8-12 hour dosing, draw peak and trough weekly. Troughs are drawn just before the dose and peaks are drawn 30 minutes after the end of the dose.

NURSING ORDERS:

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

Aminoglycosides:

LABS:

- ☐ CBC with differential, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ CMP, every_____(visit)(days)(weeks)(months) – Circle One
- ☐ **Urine Dipstick w/o micro (10 dip), weekly during therapy**

Daily dosing

- ☐ **Random** _____ **level, 12 hours post-dose, weekly during therapy**

Traditional dosing

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

- ☐ Labs already drawn. Date: _____

MEDICATION:

- ☐ amikacin _____ mg/kg = _____mg in sodium chloride 0.9% 100 mL IV, over 30-60 minutes
- ☐ gentamicin _____ mg/kg = _____ mg in sodium chloride 0.9% 100 mL IV, over 30-60 minutes
- ☐ tobramycin _____ mg/kg = _____ mg in sodium chloride 0.9% 100 mL IV, over 20-60 minutes

Interval: (must check one)

- ☐ ONCE
- ☐ Daily x ____ doses
- ☐ Every ____ days x ____ doses

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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: _____

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: _____

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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
- ☐ vancomycin 25 mg/kg/day in sodium chloride 0.9% IV, ONCE over 24 hours, continuous infusion via CADD (OHSU only)
- ☐ vancomycin 30 mg/kg/day in sodium chloride 0.9% IV, ONCE over 24 hours, continuous infusion via CADD (OHSU only)

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

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

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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:** _____

Central Intake:

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