

## INDEX LIST OF INFUSION FORM PDF IN FILE

- [PO500-017-N-1 \(3-19\)\\_Benlysta \(Belimumab\) Infusion Orders.pdf](#)
- [PO500-022-N-1 \(3-19\)\\_Protocol Adverse Reaction - Anaphylaxis \(Adult-Pediatric\).pdf](#)
- [PO500-026-N-1 \(3-19\)\\_Cimzia.pdf](#)
- [PO500-028-N-1 \(3-19\)\\_Fasenra \(benralizumab\) Injection Orders.pdf](#)
- [PO500-031-N-1 \(3-19\)\\_Boniva Infusion.pdf](#)
- [PO500-033-N-1 \(3-19\)\\_Actemra Infusion.pdf](#)
- [PO500-036-N-1 \(3-19\)\\_CRH Stimulation Test \(endocrinology only\).pdf](#)
- [PO500-037-N-1 \(3-19\)\\_Clonidine - Arginine Stimulation for Growth Hormone Deficiency in Children.pdf](#)
- [PO500-038-N-1 \(3-19\)\\_Entyvio \(Vedolizumab\) Infusion Orders.pdf](#)
- [PO500-039-N-1 \(3-19\)\\_Fasting Hypoglycemia Protocol.pdf](#)
- [PO500-040-N-1 \(3-19\)\\_Outpatient Orders.pdf](#)
- [PO500-041-N-1 \(3-19\)\\_Human Growth Hormone Testing.pdf](#)
- [PO500-042-N-1 \(3-19\)\\_Hydration Orders.pdf](#)
- [PO500-043-N-1 \(3-19\)\\_Immunoglobulin Intravenous \(IVIg\).pdf](#)
- [PO500-044-N-1 \(3-19\)\\_Infliximab \(Inflectra\) Infusion Orders.pdf](#)
- [PO500-045-N-1 \(3-19\)\\_Ferric Carboxymaltose \(Injectafer\) Infusion.pdf](#)
- [PO500-046-N-1 \(3-19\)\\_Alemtuzumab \(Lemtrada\) Infusion.pdf](#)
- [PO500-047-N-1 \(3-19\)\\_Mepolizumab \(Nucala\) Injection Orders.pdf](#)
- [PO500-048-N-1 \(3-19\)\\_Belatacept \(Nulojix\) Infusion.pdf](#)
- [PO500-049-N-1 \(3-19\)\\_Ocrelizumab \(Ocrevus\) Infusion Orders.pdf](#)
- [PO500-050-N-1 \(3-19\)\\_Abatacept \(Orencia\) Infusion Orders.pdf](#)
- [PO500-051-N-1 \(3-19\)\\_Outpatient Antibiotics.pdf](#)
- [PO500-053-N-1 \(3-19\)\\_ Phlebotomy Order.pdf](#)
- [PO500-054-N-1 \(3-19\)\\_Porta-Cath-Flush.pdf](#)
- [PO500-055-N-1 \(3-19\)\\_ Denosumab \(Prolia\) Injection Orders.pdf](#)
- [PO500-056-N-1 \(4-19\)\\_ Zoledronic Acid \(Reclast\) Infusion Orders.pdf](#)
- [PO500-057-N-1 \(4-19\)\\_ Rituximab \(Rituxan\) Infusion Orders.pdf](#)
- [PO500-058-N-1 \(4-19\)\\_Golimumab \(Simponi Aria\) Infusion Orders.pdf](#)
- [PO500-059-N-1 \(4-19\)\\_Methylprednisolone \(Solumedrol\) Infusion Orders.pdf](#)
- [PO500-060-N-1 \(4-19\)\\_Ustekinumab \(Stelara\) Infusion Orders.pdf](#)
- [PO500-061-N-1 \(4-19\)\\_Natalizumab \(Tysabri\) Infusion Orders.pdf](#)
- [PO500-062-N-1 \(4-19\)\\_Water Restriction Test.pdf](#)
- [PO500-063-N-1 \(4-19\)\\_Omalizumab \(Xolair\) Infusion Orders.pdf](#)
- [PO500-064-N-1 \(4-19\)\\_Mixed Meal Testing Orders.pdf](#)
- [PO500-065-N-1 \(7-19\)\\_Evenity Injection Orders.pdf](#)

# 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 1<sup>st</sup> 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

PO500-017-N-1 (3-19)

# PROTOCOL: Adverse Reaction / Anaphylaxis (Adult - Pediatric) Page 1 of 2

## 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** ⇨

Patient Identification:

St. Peter's Hospital

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

**Protocol: Adverse Adverse Reaction / Anaphylaxis  
(Adult - Pediatric)**



ORD.PHY

PO500-022-N-1 (4-19)  
Page 1 of 2

# PROTOCOL: Adverse Reaction / Anaphylaxis (Adult - Pediatric) Page 2 of 2

## 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 urticaria, pruritis and shortness of breath:**

Diphenhydramine 1 mg/kg IV every 4 hours prn urticaria or pruritis (Max 25 mg per dose), if IV unavailable may give Diphenhydramine 1 mg/kg PO every 4 hours prn urticaria 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

Patient Identification:

St. Peter's Hospital

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

**Protocol: Adverse Adverse Reaction / Anaphylaxis  
(Adult - Pediatric)**



ORD.PHY

PO500-022-N-1 (4-19)  
Page 2 of 2

# 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 1<sup>st</sup> 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 1<sup>st</sup> 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  
**benralizumab (Fasenra) Injection Orders**



ORD.PHY

PO500-028-N-1 (3-19)

# 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 1<sup>st</sup> 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

**Ibandronate (Boniva) Infusion Orders**



ORD.PHY

PO500-031-N-1 (3-19)

# INFUSION ORDERS: tocilizumab (Actemra)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Ht: \_\_\_\_\_ inches Wt: \_\_\_\_\_ kg

Diagnosis: \_\_\_\_\_

## tocilizumab dose:

- 4 mg/kg IV 1<sup>st</sup> 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 1<sup>st</sup> 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

**Tocilizumab (Actemra) Infusion Orders**



ORD.PHY

PO500-033-N-1 (3-19)



# 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)**



ORD . PHY

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<sup>2</sup> as a single dose. You can use <http://www.globalrph.com/bsa2.htm> to calculate body surface area in m<sup>2</sup>

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 postural 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

PO500-037-N-1 (3-19)

# 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 1<sup>st</sup> 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

PO500-038-N-1 (3-19)

# 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 sulfonyleurea screen (urine).
  - a. Send the glucose and the sulfonyleurea 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 >**

PATIENT IDENTIFICATION:

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

## Fasting Hypoglycemia Protocol



ORD.PHY

PO500-039-N-1 (3-19)

Page 1 of 2

# 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:

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

## Fasting Hypoglycemia Protocol



ORD . PHY

PO500-039-N-1 (3-19)  
Page 2 of 2

# 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

PO500-040-N-1 (3-19)

# 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**



PO500-041-N-1 (3-19)

# 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

PO500-042-N-1 (3-19)



# 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 1<sup>st</sup> 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 (Inflixtra)

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

**Infusion Orders Infliximab (Inflixtra)**



ORD.PHY

PO500-044-N-1 (3-19)

Page 1 of 2

# 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

PO500-044-N-1 (3-19)  
Page 2 of 2

# 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 1<sup>st</sup> 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

PO500-045-N-1 (3-19)

# 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

PO500-046-N-1 (3-19)

# 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 polyangiitis 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



ORD.PHY

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 1<sup>st</sup> 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

PO500-048-N-1 (3-19)

# 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

PO500-050-N-1 (3-19)

# 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 1<sup>st</sup> 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**



PO500-055-N-1 (3-19)

# 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 1<sup>st</sup> 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**



PO500-056-N-1 (4-19)

# 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<sup>2</sup> 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**



PO500-057-N-1 (4-19)  
Page 1 of 2

# 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**



PO500-057-N-1 (4-19)  
Page 2 of 2



# 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 1<sup>st</sup> 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**



PO500-058-N-1 (4-19)

# INFUSION ORDERS: methylprednisolone (Solumedrol)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Ht: \_\_\_\_\_ inches Wt: \_\_\_\_\_ kg

Diagnosis: \_\_\_\_\_

**methylprednisolone dose:**

\_\_\_\_\_ IV\_ X\_\_\_\_\_ days, infused over one hour

If 1<sup>st</sup> 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: \_\_\_\_\_

Ht: \_\_\_\_\_ inches Wt: \_\_\_\_\_ 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

### Maintenance dose is given subcutaneously:

90 mg every 8 weeks, begin maintenance dosing 8 weeks after the IV induction dose.

## For Plaque Psoriasis:

### 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 >**

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 (4-19)

Page 1 of 2

# INFUSION ORDERS: ustekinumab (Stelara)

(Continued from page 1)

## For Psoriatic Arthritis:

- 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 1<sup>st</sup> 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

**Ustekinumab (Stelara) Infusion Orders**



PO500-060-N-1 (4-19)  
Page 2 of 2

# 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 1<sup>st</sup> 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**



PO500-061-N-1 (4-19)

# 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 >**

PATIENT IDENTIFICATION:

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

**Water Restriction Test**



ORD.PHY

PO500-062-N-1 (4-19)

Page 1 of 2

# 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:

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

**Water Restriction Test**



ORD.PHY

PO500-062-N-1 (4-19)

Page 2 of 2

# 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

PO500-063-N-1 (4-19)



# 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**



PO500-065-N-1 (7-19)