



Spectrum Health

**Physician's Orders
OCTREOTIDE
(SANDOSTATIN LAR DEPOT) -
ADULT, OUTPATIENT,
INFUSION CENTER**

Page 1 to 2

Patient Name
DOB
MRN
Physician
FIN

Defaults for orders not otherwise specified below:

- Interval: Every 28 days
- Interval: Every ___ days

Duration:

- Until date: _____
- 1 year
- _____ # of Treatments

Anticipated Infusion Date _____ ICD 10 Code with Description _____

Height _____ (cm) Weight _____ (kg) Allergies _____

Provider Specialty

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Allergy/Immunology | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> OB/GYN | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Internal Med/Family Practice | <input type="checkbox"/> Other | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Genetics | <input type="checkbox"/> Neurology | <input type="checkbox"/> Pulmonary | <input type="checkbox"/> Wound Care |
- Site of Service
- | | | | |
|--|--|---------------------------------------|---|
| <input type="checkbox"/> SH Gerber | <input type="checkbox"/> SH Lemmen Holton (GR) | <input type="checkbox"/> SH Pennock | <input type="checkbox"/> SH United Memorial |
| <input type="checkbox"/> SH Helen DeVos (GR) | <input type="checkbox"/> SH Ludington | <input type="checkbox"/> SH Reed City | <input type="checkbox"/> SH Zeeland |

Appointment Requests

- Infusion Appointment Request**
Status: Future, Expected: S, Expires: S+366, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Injection and possible labs

Safety Parameters and Special Instructions

- ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 4**
OCTREOTIDE (SANDOSTATIN LAR DEPOT):

M depot injection: Patients must be stabilized on subcutaneous octreotide for at least 2 weeks before switching to the long-acting depot. Upon switch: 20 mg IM intragluteally every 4 weeks. Duration depends on indication. Then dose may be modified based upon response.

Monitoring Parameters:

Acromegaly: Growth hormone, somatomedin C (IGF-1)

Carcinoid: 5-HIAA, plasma serotonin and plasma substance P

VIPomas: Vasoactive intestinal peptide

Chronic therapy: Thyroid function (baseline and periodic), vitamin B12 level, blood glucose, glycemic control and antidiabetic regimen (patients with diabetes mellitus), cardiac function (heart rate, ECG), zinc level (patients with excessive fluid loss maintained on TPN)

CONTINUED ON PAGE 2 →

NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.



Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.



Spectrum Health

**OCTREOTIDE
(SANDOSTATIN LAR DEPOT) -
ADULT, OUTPATIENT,
INFUSION CENTER
(CONTINUED)**

Page 2 to 2

Patient Name
DOB
MRN
Physician
FIN



Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.



Labs

	Interval	Duration
<input type="checkbox"/> Thyroid Stimulating Hormone (TSH) Level	<input type="checkbox"/> Every ___ days <input type="checkbox"/> Once	<input type="checkbox"/> Until date: _____ <input type="checkbox"/> 1 year <input type="checkbox"/> _____ # of Treatments
Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous		
<input type="checkbox"/> T4 (Thyroxine), Free, Blood Level	<input type="checkbox"/> Every ___ days <input type="checkbox"/> Once	<input type="checkbox"/> Until date: _____ <input type="checkbox"/> 1 year <input type="checkbox"/> _____ # of Treatments
Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous		
<input type="checkbox"/> Parathyroid Hormone (PTH) Intact	<input type="checkbox"/> Every ___ days <input type="checkbox"/> Once	<input type="checkbox"/> Until date: _____ <input type="checkbox"/> 1 year <input type="checkbox"/> _____ # of Treatments
Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous		
<input type="checkbox"/> Vitamin B12 Blood Level	<input type="checkbox"/> Every ___ days <input type="checkbox"/> Once	<input type="checkbox"/> Until date: _____ <input type="checkbox"/> 1 year <input type="checkbox"/> _____ # of Treatments
Status: Future, Expected: S, Expires: S+184, URGENT, Clinic Collect, Blood, Blood, Venous		

Additional Lab Orders

<input type="checkbox"/> Labs: _____	<input type="checkbox"/> Every ___ days <input type="checkbox"/> Once	<input type="checkbox"/> Until date: _____ <input type="checkbox"/> 1 year <input type="checkbox"/> _____ # of Treatments
--------------------------------------	--	---

Medications

<input checked="" type="checkbox"/> octreotide (SandoSTATIN LAR) injection kit Intramuscular, for 3 Minutes, Once, Starting S, For 1 Doses Doses: <input type="checkbox"/> 10 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 30 mg <input type="checkbox"/> 40 mg <input type="checkbox"/> _____ mg Depot formulation: Administer IM intragluteal (avoid deltoid administration); alternate gluteal injection sites to avoid irritation. For IM administration only; do not administer depot formulation (Sandostatatin LAR) intravenously or subcutaneously; MUST BE ADMINISTERED IMMEDIATELY AFTER MIXING

Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED: TIME	DATE	VALIDATED: TIME	DATE	ORDERED: TIME	DATE	Pager #
		Sign		R.N. Sign		Physician Print
						Physician

EPIC VERSION DATE: 07/16/20