

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+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion

Provider Reminder

- ONC PROVIDER REMINDER 10**
 Pretreatment with antihistamines or antipyretics is not required per package insert. For symptoms of allergic reaction or anaphylaxis, order "Peds Hypersensitivity Reactions Therapy Plan".

Lab Orders

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

Pre-Medications

- Pre-medication with dose: _____
- Pre-medication with dose: _____

Medications

- reslizumab (CINQUAIR) 3 mg/kg in sodium chloride 0.9 % 50 mL IVPB**
 3 mg/kg, Intravenous, Administer over 50 Minutes, Once, Starting S, For 1 Dose
 Do not administer as IV Push or Bolus. Protect from light. Do not Shake.

CONTINUED ON PAGE 2 →

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



Nursing Orders



ONC NURSING COMMUNICATION 23

- Place intermittent infusion device as necessary.

- Infuse through a 0.2 micron, low protein binding inline filter.

- Do not administer if the solution is discolored or if foreign particulate matter is present. Solution should look clear to slightly hazy/opalescent, colorless to slight yellow; proteinaceous particles that appear translucent to white may be present in the solution.

- Monitor vital signs with Pulse oximetry. Obtain heart rate, respiratory rate, blood pressure and pulse oximetry and assess for symptoms of anaphylaxis every 15 minutes through 30 minutes after drug completion.

- Notify attending physician, NP, PA-C and stop infusion immediately if patient has itching, hives, swelling, fever, rigors, dyspnea, cough or bronchospasm. Notify if greater than 20% decrease in systolic or diastolic blood pressure.

- At the end of infusion, flush secondary line with 0.9% Sodium Chloride.

- Verify that patient has diphenhydramine / Epi-pen available (as appropriate) for immediate home use. Advise patient that severe hypersensitivity or anaphylactic reactions may occur during and after infusion. Inform patients of signs and symptoms of anaphylaxis and hypersensitivity reactions, and importance of seeking medical care.



ONC NURSING COMMUNICATION 2

- Observe patient in the infusion center for 30 minutes following completion of infusion.



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.



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

EPIC VERSION DATE: 04/01/19