Spectrum Health Helen DeVos children's hospital

Physician's Orders RESILIZUMAB - PEDIATRIC, OUTPATIENT, INFUSION CENTER

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

☐ Allergy/Immunology	☐ Infectious Disease	☐ OB/GYN	☐ Rheumatology
☐ Cardiology	☐ Internal Med/Family Practice	☐ Other	☐ Surgery
☐ Gastroenterology	☐ Nephrology	☐ Otolaryngology	☐ Urology
☐ Genetics	☐ Neurology	☐ Pulmonary	☐ Wound Care

Site of Service

☐ SH Gerber	☐ SH Lemmen Holton (GR)	☐ SH Pennock	☐ SH United Memorial
☐ SH Helen DeVos (GR)	☐ SH Ludington	☐ SH Reed City	☐ 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, 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".

Labs

		Interval	Duration
☐	Other Labs: _____	☐ Every ___days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments

Pre-medications:

☐ Pre-medication with dose: _____

☐ Pre-medication with dose: _____

Medications

☑ reslizumab (CINQAIR) 3 mg/kg in sodium chloride 0.9 % 50 mL IVPB
3 mg/kg, Intravenous, for 50 Minutes, Once, Starting S, For 1 Doses
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.***

Spectrum Health Helen DeVos children's hospital

RESILIZUMAB - PEDIATRIC, OUTPATIENT, INFUSION CENTER *(CONTINUED)*

Patient Name

DOB

MRN

Physician

FIN

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.

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:**			
TIME	**DATE**	**TIME**	**DATE**	**TIME**	**DATE**	Pager #	
	Sign		**R.N. Sign**		**Physician Print**		**Physician**

EPIC VERSION DATE: 04/01/19

