Oregon Health & Science University Hospital and Clinics Provider's Orders PO7071 ADULT AMBULATORY INFUSION ORDER **Voriconazole (VFEND) Infusion** Page 1 of 3	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. Required referral information: Recent H&P or chart notes, current home medication list, problem list, allergies, sensitivities, insurance and relevant lab values. If using this order form to request antibiotics from a home health agency, be sure to specify frequency and duration of therapy at the bottom of the order. Examples of frequency include Q8H, Q12H or once daily. Examples of duration include 7 days, 14 days, or 1 month.
3. May use ambulatory pump for antibiotic administration if needed (excluding Medicare patients).
4. Concomitant use is contraindicated with the following:
   - Barbiturates (long acting)
   - Carbamazepine
   - CYP 3A4 substrates (terfenadine, astemizole, cisapride, pimozide, quinidine)
   - Ergot alkaloids
   - Efavirenz (standard doses)
   - Rifabutin
   - Rifampin
   - Ritonavir (≥800 mg/day)
   - Sirolimus
   - St. John's Wort
5. Consider limiting the use of IV voriconazole in patients with renal impairment. In patients with CrCl less than 50 mL/min, accumulation of the intravenous vehicle (cyclodextrin) may occur. Oral voriconazole should be administered unless benefit of IV therapy outweighs risk.
6. Hepatic dysfunction:
   a. Mild to moderate hepatic dysfunction (Child-Pugh Class A or B): Following standard loading dose, reduce maintenance dosage by 50%.
   b. Severe hepatic dysfunction: Use only if benefit outweighs potential risk; monitor closely for toxicity

LABS:

- ☐ CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ CMP, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ Labs already drawn. Date: _____

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MEDICATIONS:

Loading doses: (total of 2 doses)

- ☐ voriconazole (VFEND) 6 mg/kg = _____ mg in sodium chloride 0.9% 100 mL IV, ONCE, over 2 hours

Maintenance doses:

- ☐ voriconazole (VFEND) 4 mg/kg = _____ mg in sodium chloride 0.9% 100 mL IV, ONCE, over 2 hours
- ☐ voriconazole (VFEND) ___ mg/kg = _____ mg in sodium chloride 0.9% 100 mL IV, ONCE, over 1-2 hours

Rate NTE 3 mg/kg/hr. Do not infuse concomitantly into same line or cannula with other drug infusions

NURSING ORDERS:

1. Do not infuse concomitantly with blood products or short-term concentrated electrolyte solutions, even if the two infusions are running in separate intravenous lines or cannulas.
2. Flush IV line with 5 mL NaCl 0.9% before and after each infusion. Flush IV line with 20 - 30 mL NaCl 0.9% after each lab draw. For line maintenance flush each unused lumen(s) of the line with 5 mL NaCl 0.9% once weekly.
3. Weekly and prn PICC line dressing changes. Biopatch to insertion site with each dressing change. Change caps weekly and after lab draws.

FOR InfuSystem™ AMBULATORY PUMP USE (hook up at infusion location):

Frequency:

- ☐ Q12H

Duration:

- ☐ 7 days
- ☐ 14 days
- ☐ _____ days
- ☐ 1 month

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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