Spectrum Health

Patient Name
DOB
MRN
Physician
FIN

Physician's Orders
CYTOMEGALOVIRUS IMMUNE GLOBULIN HUMAN (CYTOGAM) - ADULT, OUTPATIENT, INFUSION CENTER

Defaults for orders not otherwise specified below:
- ☐ Interval: Every 14 days
- ☐ Interval: Weeks 12 & 16 post-transplant
- ☐ Interval: Every ___ days

Duration:
- ☐ 4 Treatments
- ☐ 2 Treatments (weeks 12 & 16 post-transplant)
- ☐ Until date: _____
- ☐ _____# 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+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion and possible labs

Labs - FOR WEEKS 12 & 16 ONLY

	Interval	Duration
☑ IgG, Blood Level	Once	1 treatment

Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous

Additional Lab Orders

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

Nursing Orders

☑ ONC NURSING COMMUNICATION 11
CYTOMEGALOVIRUS IMMUNE GLOBULIN (CYTOGAM):

If mild reactions occur (headache, flushing, dizziness, nausea, chills, mild hypotension): Temporarily stop or slow infusion rate. Notify ordering physician/NP/PA. If symptoms subside promptly, the infusion may be resumed at a lower rate (that does not result in recurrence of the symptoms).

For severe reactions (including anaphylaxis): Discontinue Cytogam and notify ordering physician/NP/PA.

Obtain vital signs (temperature, BP, HR and RR) and oxygen saturation during administration. During administration, the patient's vital signs should be monitored continuously and careful observation made for any symptoms throughout the infusion.

☑ ONC NURSING COMMUNICATION 100
May Initiate IV Catheter Patency Adult Protocol

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

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CYTOMEGALOVIRUS IMMUNE GLOBULIN HUMAN (CYTOGAM) - ADULT, OUTPATIENT, INFUSION CENTER *(CONTINUED)*

Nursing Orders (continued)

Vitals

☑ Vital Signs
Routine, PRN, Starting S, For Until specified
Vital signs should be taken pre-infusion, mid-way and post-infusion as well as before any rate increases. During administration of cytomegalovirus immune globulin, the patient's vital signs should be monitored continuously and careful observation made for any symptoms throughout the infusion.

Pre-Medications

☑ acetaminophen (TYLENOL) tablet 650 mg
650 mg, Oral, Once, Starting H, For 1 Doses

☑ diphenhydrAMINE (BENADRYL) capsule 25 mg
25 mg, Oral, Once, Starting S, For 1 Doses

☐ ondansetron (ZOFRAN) injection 4 mg
4 mg, Intravenous, Administer over 5 Minutes, Once, Starting S, For 1 Doses

☐ furosemide (LASIX) injection 20 mg
20 mg, Intravenous, Administer over 2 Minutes, Once, Starting S, For 1 Doses

Additional Pre-Medications

☐ Pre-medication with dose: _____

Medications

☑ cytomegalovirus immune glob (CYTOGAM) infusion
Dose:
☐ 50 mg/kg
☐ 100 mg/kg (common dosing for weeks 12 & 16)
☐ 150 mg/kg (common dosing for every 2 weeks x 4)

Intravenous, Titrate, Starting S+30 Minutes, For 1 Doses
Concentration = 50 mg/mL.

All patients with actual body weight greater than or equal to ideal body weight (IBW) (non-underweight patients), should be initially dose using IBW.

Administer through a dedicated IV line containing an in-line 15 micron filter (a 0.2 micron filter is also acceptable). Do not mix with other infusions; do not use if turbid. Infusion with other products is not recommended; however, if unavoidable, may be piggybacked into an IV line of NS, D5W, D10W, or dextrose 20% in water. Do not dilute more than 1:2.

Initial infusion: Begin infusion at 15 mg/kg/hour (0.3mL/kg/hour). If no adverse reactions occur within 30 minutes, may increase rate to 30 mg/kg/hour (0.6mL/kg/hour). If no adverse reactions occur within the second 30 minutes, may increase rate to 60 mg/kg/hour (1.2mL/kg/hour); maximum rate of infusion: 75 mL/hour.

Monitor closely after each rate change. If patient develops nausea, back pain, or flushing during infusion, slow the rate or temporarily stop the infusion. Discontinue if blood pressure drops or in case of anaphylactic reaction.

Subsequent infusions: Initiate at 15 mg/kg/hour (0.3 mL/kg/hour) for the first 15 minutes, if no infusion-related reactions, increase to 30 mg/kg/hour (0.6 mL/kg/hour) for the next 15 minutes; if rate is tolerated, increase to 60 mg/kg/hour (1.2 mL/kg/hour) and maintain this rate until completion of dose; maximum infusion rate: 60 mg/kg/hour (1.2 mL/kg/hour) or not to exceed 75 mL/hour.

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

