



Phone: 800-809-1265

MRN: _____

DOB: _____

STANDARD VISTIDE PLAN OF TREATMENT

(Re) Certification Dates: From: _____ to: _____

NOTE: Patient's appointment to receive Vistide will be rescheduled, if receiving antibiotic for active infectious process due to the possibility of developing a superinfection related to its effect on the immune status, or has a suspected infectious process.

Patient Name _____ **Weight** _____ **Height** _____ **Allergies:** _____

Diagnosis: Primary Diagnosis: ICD-10 B60.8 BK Neuropathy

Secondary Diagnosis: ICD-10 Z94.0 Kidney Transplant. ICD-10 T86.10 Unspecified complication of kidney transplant

Date of Kidney Transplant: _____

Premedicate X 1 dose 30 minutes before each infusion with: None or

Acetaminophen 650mg PO Diphenhydramine 50 mg PO Fexofenadine ___ 60 mg ___ 180 mg PO Cetirizine 10mg PO

Loratadine 10 mg OR Premedicate with other _____

Patient given prescription for: (per manufacturer's guidelines, patient to obtain from local pharmacy)

Probenecid 2 grams po 3 hours prior to infusion and 1 gram po at 2 and 8 hr. interval after infusion

Orders:

Obtain weight each visit. Vital signs every 30 minutes beginning with start of infusion and 30 minutes after completion. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient for response to therapy.

If adverse drug reaction, implement the Standing Adverse Reaction Protocol. Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn. Normal Saline Flush 3-10 ml before infusion, followed by Heparin 100 units/ml 1 – 5 ml per line type. Pump, tubing, and supplies needed to complete prescribed therapy.

Pre-Hydration Orders: Infuse 1000ml of Normal Saline over 1-2hr(s) Before Vistide infusion

Post Hydration Orders: Infuse 1000ml of Normal Saline over 1-3 hr(s) After Vistide infusion

Dose: to be infused over 1 hours or greater as tolerated every 2 weeks

_____ **Vistide 5mg/kg in 100ml NS IV**

_____ **Vistide _____mg/kg in 100 ml NS IV**

Lab Orders: (Should be done 48 hours prior to each infusion)

_____ **BK level, CBC, Renal panel**

******* DO NOT INFUSE if CC \leq 55ml/min or urine protein \geq 100mg/dl- Notify MD*******

Notify MD:

If patient has an increase in serum creatinine of 0.3-0.4 mg/dl above baseline: Reduce dose to 3mg/kg.

Discontinue Vistide if patient has an increase in serum creatinine of \geq 0.5 mg/dl above baseline or development of \geq 3+ proteinuria

OTHER: Pharmacist to perform clinical drug monitoring.

(No Stamped Signatures, Please)

Physician's Signature: _____

(Dispense as written)

_____ Date: _____

(Substitution permitted)

Print Physician Name: _____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION to:

866-872-8920