Palmetto INFUSION

Phone: 800-809-1265

MRN:_____

DOB: _____

STANDARD VISTIDE PLAN OF TREATMENT

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 ≤ 55ml/min or urine protein ≥ 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 ≥ 0.5 mg/dl above baseline or development of ≥ 3+ proteinuria

OTHER: Pharmacist to perform clinical drug monitoring.

(No Stamped Signatures, Please)

Physician's Signature: _____ _____Date: _____

(Dispense as written) (Substitution permitted)

Print Physician Name:_____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION to:

866-872-8920