
 <p style="text-align: center;">Oregon Health & Science University Hospital and Clinics Provider's Orders</p> <p style="font-size: small;">PO9031</p>  <p style="text-align: center;">ADULT AMBULATORY INFUSION ORDER Dupilumab (DUPIXENT) injection</p> <p style="text-align: center;">Page 1 of 2</p>	<p>ACCOUNT NO. _____</p> <p>MED. REC. NO. _____</p> <p>NAME _____</p> <p>BIRTHDATE _____</p> <p style="text-align: right; font-size: x-small;"><i>Patient Identification</i></p>
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. Hypersensitivity reactions have been reported, including generalized urticaria and serum sickness or serum sickness-like reactions. Discontinue dupilumab if clinically significant hypersensitivity reaction occurs
3. Conjunctivitis and keratitis have been reported.
4. Avoid use of live vaccines in patients treated with dupilumab.

MEDICATIONS:

dupilumab (DUPIXENT) injection, subcutaneous, ONCE

Initial Dose:

600 mg (given as two 300 mg injections)

Maintenance Doses:

300 mg, every 2 weeks for _____ doses

NURSING ORDERS:

1. Advise patient to report signs/symptoms of hypersensitivity, including urticaria or symptoms of serum sickness or serum sickness-like reactions.
2. Advise patient to report new onset or worsening eye symptoms, including conjunctivitis, keratitis, or blepharitis.
3. Advise patient with comorbid asthma not to adjust or discontinue asthma treatment without consultation with a physician
4. Prior to administration, remove prefilled syringe from the refrigerator and allow to warm at room temperature for 45 minutes.
5. Administer subcutaneously into the upper arm, thigh, or abdomen (avoiding areas within 2 inches of navel). Rotate injection site with each injection. Do not inject into skin that is tender, damaged, bruised, or scarred.
6. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.



Oregon Health & Science University
Hospital and Clinics Provider's Orders

ADULT AMBULATORY INFUSION ORDER
**Dupilumab (DUPIXENT)
injection**

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ACCOUNT NO.
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NAME
BIRTHDATE

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HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

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:** _____

Please check the appropriate box for the patient's preferred clinic location:

Hillsboro Medical Center
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

Adventist Health Portland
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756

Mid-Columbia Medical Center
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610