

PEDIATRIC HOME INFUSION PROTOCOL DISCLAIMER



**** THIS FORM MUST BE INITIALED AND RETURNED WITH PRESCRIPTION ****

ATTENTION PROVIDER:

Prior to signing orders, you will need to define the dose, interval, and the number of treatments. Tri-Unity Infusion Services will follow a flat dose or dose by weight, as specified on the prescription. Tri-Unity Infusion Services Nursing Staff will initiate **Peripheral Intravenous (PIV) access** for the administration of ordered medication, unless specified on prescription to administer via a previously placed PICC line or Port-a-cath. Tri-Unity Infusion Services will forward nursing administration notes to the provider following the infusion.

LABS REQUIRED (within the last 6 months):

- Negative TB screening prior to starting therapy with Entyvio, Remicade, or Skyrizi
- Negative HBV prior to starting therapy with Remicade
- LFT panel and Bilirubin prior to starting therapy with Skyrizi
- Additional LFT Panel to be drawn between weeks 4-8 after starting Skyrizi

PRE-MEDICATIONS AND STANDING ORDER

IF NO PRE-MEDICATIONS ARE SPECIFIED BY THE PRESCRIBER ON THE PRESCRIPTION, THE FOLLOWING WILL BE DISPENSED IN THE APPROPRIATE FORM:

- Acetaminophen (Tylenol) 15mg/kg (650mg max), PO, Once, 30 minutes prior to infusion
- Diphenhydramine (Benadryl) 1-2mg/kg (50mg max), PO, Once, 30 minutes prior to infusion

PRN MEDICATIONS

- Acetaminophen (Tylenol) 15 mg/kg, PO, Every 4 hours, PRN for mild pain, fever
- Diphenhydramine (Benadryl) 1-2 mg/kg, IVPush, Every 4 hours, PRN for itching, urticaria, pruritus, or shortness of breath
- Zofran 0.1 mg/kg for patients under 40 kg and 0.4 mg/kg for patients over 40 kg, IVPush, for nausea. Only for patients over 6 months.

ANAPHYLAXIS REACTION/HYPERSENSITIVITY

- Diphenhydramine (Benadryl) 25 mg IVPush, PRN for Hypersensitivity Reaction or itching. May repeat Once if symptoms persist after 30 minutes
- Epinephrine (Adrenaline) .01 mg/kg, 1:1000, Subcutaneously, Once, As Needed for Anaphylaxis or Severe Bronchospasm.

911 WILL BE CALLED AND PHYSICIAN WILL BE NOTIFIED

- Sodium Chloride 0.9% IV Bolus 20 ml/kg x2, Once, PRN for Hypersensitivity and/or Anaphylaxis Reaction
- Solumedrol 1-2 mg/kg, Once, PRN for Hypersensitivity and/or Anaphylaxis Reaction

TITRATION

Ambulatory Infusion Pump will be titrated by the Pharmacist in Charge as instructed on medication package insert, unless otherwise noted on prescription.

PROTOCOL CONFIRMED BY PRESCRIBER

MD NAME

KEEP ON FILE

INITIAL