**OPAT:**

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| .opatHMC | \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*  OPAT Indication: \_  Medication: \_  Anticipated Duration: \_ (start date: \_)  Homeless: \_  Comorbidities (Y/N):  ESRD on HD: \_  Diabetes: \_  On immunosuppressive therapy: \_  HIV: \_  Hepatitis C: \_  Substance use:  Current (< 3months)  Recent (4-12 months)  Remote (>1 year)  IDU: Y/N (current, recent, or remote?)  Drugs used (Y/N):  Methamphetamine: \_  Heroin: \_  Cocaine: \_  Labs: Please check weekly: CBC with diff, BMP, vancomycin trough  Fax labs to ID Clinic at 206 744-6564  Do not stop antibiotics prior to ID clinic appointment or discussion with Harborview ID provider  Please have CCN schedule appointment in ID clinic for the week of: \_  If CCN not able to schedule patient, please contact our PCC Brittany McDermott at 744-2308 for an appointment, or email: brittm82@uw.edu  This document is CC’ed to HMC\_OPAT\_ID |
| .opatSOT | \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*  OPAT Indication: \_  Medication: \_  Anticipated Duration: \_ (start date: \_)  Labs: Please check weekly: CBC with diff, CMP, vancomycin trough  Fax labs to ID Clinic at 206-598-5028  DO NOT STOP ANTIBIOTICS PRIOR TO ID CLINIC APPOINTMENT OR DISCUSSION WITH UW ID PROVIDER.  **Please have CCN schedule appointment in ID clinic for the week of: \_**  If CCN not able to schedule patient, please contact our ID clinic: 206-598-1687 or id\_clinic@uw.edu  Relevant comorbidities: \_  ESRD on HD: \_  Substance use: Current (< 3months) Recent (4-12 months) Remote (>1 year)  IDU: \_  Access: PICC/ Hickman/ Port (remove PICC at completion of therapy)  Dispo: SNF/ Home / TBD  This document is CC’ed to Kara Britten |
| .opatSCCA | \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*  OPAT Recommendations    Antibiotic indication: \_  Outpatient antimicrobial regimen (specify dose, frequency, start date, and end date):  1. \_  2. \_  3. \_    Suppressive antibiotics following IV course? Yes/ No  Suppressive antimicrobial regimen (specify dose, frequency, start date, and end date):  1. \_  2. \_  3. \_    IV Access: \_  Discharge location (if known): \_    Laboratory monitoring: \_    Please fax outpatient laboratory results to: 206-667-4411    Please contact the SCCA OPAT Team at 206-667-4962 Monday-Thursday 8AM-5PM for questions related to outpatient antibiotic management. After hours and on weekends, please contact the paging operator at 206-598-6190 for the SCCA ID Fellow.  This document is CC’ed to SCCA\_OPAT\_ID |
| .opatUW | \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*  OPAT Indication: \_  Medication: \_  Anticipated Duration: \_ (start date: \_)  Labs: Please check weekly: CBC with diff, CMP, vancomycin trough  Fax labs to ID Clinic at 206-598-5028  DO NOT STOP ANTIBIOTICS PRIOR TO ID CLINIC APPOINTMENT OR DISCUSSION WITH UW ID PROVIDER.  **Please have CCN schedule appointment in ID clinic for the week of: \_**  If CCN not able to schedule patient, please contact our ID clinic: 206-598-1687 or id\_clinic@uw.edu  Relevant comorbidities: \_  ESRD on HD: \_  Substance use: Current (< 3months) Recent (4-12 months) Remote (>1 year)  IDU: \_  Access: PICC/ Hickman/ Port (remove PICC at completion of therapy)  Dispo: SNF/ Home / TBD  This document is CC’ed to Jina Taub |

**Antibiotic side effects:**

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| .RIPEside | For patients taking RIPE:  Obtain baseline LFTs. Routine monitoring of LFTs is not required unless patients have pre-existing liver disease or abnormal LFTs that do not require discontinuation of the drug, then LFTs should be monitored monthly and when symptoms occur.  Check for drug-drug interactions with rifampin.  Isoniazid can cause peripheral neuropathy. Monitor closely for this side-effect and adding pyridoxine 50mg/day is recommended.  Perform baseline and monthly visual acuity testing and testing of color discrimination while on ethambutol. | |
| .levoside | Oral levofloxacin should not be taken with calcium containing products, multivitamins, or dairy. Take levofloxacin either 2 hours before or 2 hours after these products.  Levofloxacin is associated with QT prolongation. QTc prior to starting levofloxacin is \_  Levofloxacin is also associated with tendinopathy and rarely tendon rupture, an increased risk of aortic dissection, CNS toxicity, neuropathy, and dysglycemia. The patient has been counseled regarding these risks. |
| .moxiside | Oral moxifloxacin should not be taken with calcium containing products, multivitamins, or dairy. Take moxifloxacin either 2 hours before or 2 hours after these products.  Moxifloxacin is associated with QT prolongation. QTc prior to starting moxifloxacin is \_  Moxifloxacin is also associated with tendinopathy and rarely tendon rupture, an increased risk of aortic dissection, CNS toxicity, neuropathy, and dysglycemia. The patient has been counseled regarding these risks.  Moxifloxacin often requires prior authorization. It may be prudent to pursue this 2-3 days prior to discharge. Contact ID if there are issues securing prior authorization. |
| .ciproside | Ciprofloxacin should not be taken with calcium containing products, multivitamins, or dairy. Take ciprofloxacin either 2 hours before or 2 hours after these products.  Ciprofloxacin is associated with QT prolongation. QTc prior to starting ciprofloxacin is \_  Ciprofloxacin is also associated with tendinopathy and rarely tendon rupture, an increased risk of aortic dissection, CNS toxicity, neuropathy, and dysglycemia. The patient has been counseled regarding these risks. |
| .colistinside | Intravenous colistin is associated with a high rate of nephrotoxicity. Avoid concomitant nephrotoxic medications. Establish and maintain euvolemia. Patients often require pre-hydration with IV fluids.  Colistin is also associated with neurotoxicity including paresthesias and neuromuscular blockade.  Check at least twice weekly BMP and weekly CBC with differential while on therapy. |
| .polybside | Polymyxin B is associated with nephrotoxicity. Avoid concomitant nephrotoxic medications. Establish and maintain euvolemia. Patients often require pre-hydration with IV fluids.  Polymyxin B is also associated with neurotoxicity including parasthesias and neuromuscular blockade.  Check at least twice weekly BMP and weekly CBC with differential while on therapy. |
| .daptoside | Daptomycin is associated with myopathy and rarely with rhabdomyolysis. Baseline and weekly CPK monitoring are recommended. Concurrent statin therapy should be evaluated if CPK is elevated.  Other adverse events include rash and eosinophilic pneumonia. Check weekly CBC with differential, CMP, and CPK while on therapy. |
| .doxyside | Oral doxycycline should not be taken with calcium containing products, multivitamins, or dairy. Take doxycycline either 2 hours before or 2 hours after these products.  Doxycycline can cause photosensitivity and GI ulceration. Have patient stand or sit upright for at least 30 minutes after each oral dose. |
| .linezolidside | Linezolid is associated with cytopenias, usually after 14 days. Monitor for anemia, neutropenia, thrombocytopenia, peripheral neuropathy, and optic neuritis with longer treatment courses.  Linezolid is a weak monoamine oxidase inhibitor (MAOI), and can cause serotonin syndrome especially in combination with other serotonergic drugs. Monitor for fever, tachycardia, hypertension, dysautonomia, myoclonus, rigidity, agitation.  Check a weekly CBC with diff weekly while on therapy. |
| .metroside | Metronidazole can cause a metallic taste and is associated with a disulfiram-like reaction to alcohol up to 72 hours after the last dose; symptoms include flushing, cramps, headaches, tachycardia, and nausea/vomiting. The patient has been counseled to abstain from alcohol while taking metronidazole.  Metronidazole can cause neuropathy and other CNS effects with courses greater than two weeks. |
| .rifside | Rifampin can be associated with hepatotoxicity and coagulopathy. Drug monitoring should include baseline and symptom driven LFTs.  Rifampin causes urine, tears, and other secretions to turn red-orange.  Rifampin is a potent inducer of drug metabolizing enzymes such as cytochrome P450 and P-glycoprotein. This can lead to reduced concentrations of concomitant medications. Review all of the patient’s medications when starting/stopping rifampin and consider dose-adjustment. Some important interactions include decreased levels of antimicrobials, anti-epileptics, immunosuppressants, anticoagulants, hormonal contraceptives and selected opioids.  Onset and offset of these interactions may take days to weeks with starting/stopping rifampin. Monitor patients closely both at the start and end of therapy. Consult pharmacy for drug interactions. |
| .acyclovirside | Intravenous acyclovir is associated with nephrotoxicity. Avoid concomitant nephrotoxic medications. Establish and maintain euvolemia. Patients often require pre-hydration with IV fluids.  Check weekly CBC with diff and BMP while on high dose IV acyclovir. |
| .aminoglycosideside | Aminoglycosides are associated with nephrotoxicity. Avoid concomitant nephrotoxic medications. Establish and maintain euvolemia.  They are also associated with ototoxicity. Patients receiving >14 days of treatment should have a baseline audiogram prior to or within 3-5 days of starting therapy, and repeat audiogram monthly thereafter.  Once on a stable dose, check a SCr twice weekly and check an aminoglycoside serum level weekly. |
| .amphoside | Ambisome is associated with nephrotoxicity and electrolyte wasting. Avoid concomitant nephrotoxic medications and provide pre- and post- hydration.  Monitor for infusion reactions such as chills, rigors, and myalgias. Consider pre-medication with acetaminophen, diphenhydramine, or meperidine.    Check a baseline CBC with diff, CMP, Mg, and Phos daily until stable. Once stable, check twice weekly BMP, Mg, Ca, Phos and weekly CBC with diff and LFTs. |
| .posaside | Posaconazole is associated with hepatotoxicity. Check a BMP and LFTs twice monthly. Consider stopping posaconazole if transaminases are >3x ULN.  Check a posaconazole level 7-10 days after initiation. Goal trough is >0.7 mcg/mL for prophylaxis and > 1 mcg/mL for treatment dosing. Monitor trough levels at least monthly thereafter.  Posaconazole is associated with QTc prolongation. QTc prior to starting posaconazole is \_.  Posaconazole is associated with drug interactions and patient medication lists should be reviewed upon initiation. |
| .voriside | Voriconazole is associated with hepatotoxicity. Check a CMP weekly in the first month and then monthly thereafter. Consider stopping voriconazole if transaminases are >3x ULN.  Check a voriconazole trough 5-7 days after initiation. Goal trough is 1-5.5 mg/L. Monitor trough levels at least monthly thereafter.  Voriconazole can be associated with visual disturbances, rashes, neurotoxicity, photosensitivity, and alopecia. For patients taking voriconazole for longer than 6 weeks, an ophthalmology evaluation and skin evaluation is recommended.  Voriconazole is associated with QTc prolongation. QTc prior to starting voriconazole is \_.  Voriconazole is associated with drug interactions and patient medication lists should be reviewed upon initiation. and should be reviewed upon initiation. |

**Antibiotic Labs:**

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| .labacyclovir | Check weekly CBC with diff, BMP |
| .labaminoglycoside | Check twice weekly BMP and once weekly CBC with diff. Consult a pharmacist for therapeutic drug monitoring (TDM) plan. |
| .labamox | Check weekly CBC with diff, BMP |
| .labamoxclav | Check weekly CBC with diff, BMP. Monthly LFTs if on prolonged treatment. |
| .labampicillin | Check weekly CBC with diff, BMP and LFTs. |
| .labampsulb | Check weekly CBC with diff, BMT and LFTs |
| .labampho | Check BMP, Ca, Mag, Phos at least twice weekly. Check weekly CBC with diff and LFTs. |
| .labaztreonam | Check weekly CBC with diff, BMP and LFTs |
| .labbactrim | If on PO trimethoprim/sulfamethoxazole (TMP/SMX) doses > 1DS BID, initially check weekly CBC with diff, BMP and LFTs, then monthly if stable. If on IV TMP/SMX, check weekly CBC with diff, BMP and LFTs. |
| .labcefaz | Check weekly CBC with diff, BMP |
| .labcefepime | Check weekly CBC with diff, BMP |
| .labceftar | Check weekly CBC with diff, BMP |
| .labceftaz | Check weekly CBC with diff, BMP |
| .labcidof | Check CBC with diff, BMP, Ca, Mag, Phos at least twice weekly. UA should be checked at baseline and weekly while on cidofovir. LFTs should be monitored weekly. |
| .labclinda | Check weekly CBC with diff, BMP, and LFTs |
| .labcolistin | Check twice weekly BMP and weekly CBC with diff |
| .labCTX | Check weekly CBC with diff, BMP, LFTs |
| .labdapto | Check weekly CBC with diff, BMP, CPK |
| .laberta | Check weekly CBC with diff, BMP, LFTs |
| .labfluc | Check twice monthly LFTs |
| .labflucytosine | Check CBC with diff and BMP twice weekly. Monitor LFTs twice a month. Check flucytosine level 3-5 days after initiation of treatment. Level should be drawn 2 hours after dose administration. |
| .labfoscarnet | Check BMP, Ca, Mag, Phos at least twice weekly. Check weekly CBC with diff and LFTs. |
| .labFQ | Baseline SCr. No routine follow-up lab monitoring is required for short fluoroquinolone courses. Lab monitoring might be required for prolonged treatment with fluoroquinolones. Check baseline EKG for QTc prolongation if risk factors present, then monitor as needed (i.e. monthly). |
| .labgan | Check twice weekly CBC with diff and weekly BMP |
| .labisavu | Check LFTs twice a month. Drug levels are not routinely required. . |
| .labisonia | Monitor monthly LFTs in patients with pre-existing liver disease or prior h/o LFT elevation |
| .lablinezolid | Check weekly CBC with diff |
| .labmero | Check weekly CBC with diff, BMP, LFTs |
| .labmica | Check weekly LFTs |
| .labnafcillin | Check weekly CBC with diff, BMP, LFTs |
| .labPCN | If on parenteral penicillin, check weekly CBC with diff, BMP, LFTs |
| .labposa | Check twice monthly BMP and LFTs. Check CBC with diff monthly. Check initial posaconazole level 7-10 days after initiation and at least monthly while on therapy. |
| .labrif | Check monthly LFTs in patients at risk for liver toxicity. Consider coagulation monitoring in patients at risk for vitamin K deficiency. |
| .labtige | Check weekly CBC with diff, BMP and LFTs |
| .labvalacyclovir | Check weekly CBC with diff, BMP while on high-dose valacyclovir |
| .labvalgan | Check weekly CBC with diff, BMP while on high-dose valgancyclovir |
| .labvanco | Check weekly CBC with diff, BMP, vancomycin trough |
| .labvori | Check twice monthly BMP and Ca, Mag, Phos. Check CBC with diff monthly. Monitor LFTs weekly during the first month of therapy, then monthly. Check voriconazole trough level 5-7 days after initiation, then at least monthly while on therapy. |

**Antibiotic dosing:**

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| .dalbadose | It takes ~3 hours to order, prepare, and infuse a dose of dalbavancin. The patient MUST have a working IV line and agree to remain in the hospital until the dose is complete PRIOR to ordering dalbavancin.  For patients with CrCl >30:  The initial dose of dalbavancin is 1500mg IV x1  For patients with CrCl <30:  The initial dose of dalbavancin is 1000mg IV x1  For patients on hemodialysis:  The initial dose of dalbavancin is 1500mg IV x1  For patients with severe infections in whom we would prefer a longer duration of treatment, please schedule an outpatient visit for repeat dalbavancin at 1 week. |
| .aminodose | Initial aminoglycoside dosing should be managed by pharmacy. |
| .vancodose | Vancomycin dosing should be managed by pharmacy. |
| .merodose | For most patients:  The dose of meropenem is 1g IV Q8HR. This requires renal dose-adjustment for CrCl <50.  For patients with cystic fibrosis or meningitis:  The dose of meropenem is 2g IV Q8HR. This requires renal dose-adjustment for CrCl <50.  For isolates with intermediate susceptibility to meropenem (MIC =4):  Recommend meropenem extended infusion.  The dose of meropenem is 2g IV Q8HR infused over 3 hours. This requires renal dose-adjustment for CrCl <50. Use MDRO powerplan. |
| .acyclovirdose | For mucocutaneous HSV:  The dose of acyclovir is 5mg/kg IV Q8HR. This requires renal dose-adjustment for CrCl <50.  Use ideal body weight to calculate doses for most patients. For very obese patients, use adjusted body weight.  For HSV encephalitis:  The dose of acyclovir is 10mg/kg IV Q8HR. This requires renal dose-adjustment for CrCl <50.  Use ideal body weight to calculate doses for most patients. For very obese patients, use adjusted body weight.  For VZV infections:  The dose of acyclovir is 10mg/kg IV Q8HR. This requires renal dose-adjustment for CrCl <50.  Use ideal body weight to calculate doses for most patients. For very obese patients, use adjusted body weight. |
| .posadose | For posaconazole delayed release tabs (preferred oral):  Start posaconazole 300mg PO BID x1 day, followed by 300mg PO daily.  For posaconazole IV (restricted to ID):  Start posaconazole 300mg IV BID x1 day, followed by 300mg IV daily. Transition to oral as soon as possible.  For posaconazole oral suspension (for patients unable to swallow whole tablets):  Start posaconazole suspension 200mg/5mL enterally Q6HR for treatment.  Start posaconazole suspension 200mg/5mL enterally Q8HR for prophylaxis.  The suspension is poorly absorbed therefore may not be adequate for treating an invasive fungal infection. |
| .isavudose | Start isavuconazonium 372mg IV or PO Q8HR x6 doses (2 days), followed by 372mg PO or IV daily. |
| .gandose | For treatment of CMV disease:  The dose of ganciclovir is 5mg/kg IV Q12HR. This requires renal dose-adjustment for CrCl <70. Use total body weight to calculate doses.  For prophylaxis against CMV disease:  The dose of ganciclovir is 5mg/kg IV Q24HR. This requires renal dose-adjustment for CrCl <70. Use total body weight to calculate doses. |
| .valacyclovirdose | For herpes zoster:  The dose of valacyclovir is 1g PO Q8HR. This requires renal dose-adjustment for CrCl <50.  For HSV1/2 initial outbreaks:  The dose of valacyclovir is 1g PO Q12HR. This requires renal dose-adjustment for CrCl <50.  For HSV1/2 recurrences:  The dose of valacyclovir is 500mg PO Q12HR. This requires renal dose-adjustment for CrCl <50. |
| .valgandose | For treatment of CMV disease:  The dose of valganciclovir is 900mg PO Q12HR. This requires renal dose-adjustment for CrCl <60.  For prophylaxis against CMV disease:  The dose of valganciclovir is 900mg PO Q24HR. This requires renal dose-adjustment for CrCl <60. |
| .voridose | Start voriconazole 6mg/kg IV or PO Q12HR x1 day, followed by 4mg/kg Q12HR.  Use actual body weight to calculate doses for most patients. For very obese patients, use adjusted body weight. |
| .polybdose | Administer a loading dose of polymixin B 3mg/kg IV x1.  After 12 hours, begin maintenance with polymixin B 1.5mg IV Q12HR.  Use actual body weight to calculate doses for most patients. For very obese patients, use adjusted body weight. Doses > 450mg/day (i.e 100kg, adjusted body weight) should be approached with caution and discussed with stewardship pharmacist; MAX published dose is 625 mg/day. There is no dose-adjustment for renal function.  Administer meropenem by extended infusion concurrently with polymixin B.  The dose of meropenem is 2g IV Q8HR infused over 3 hours. This requires renal dose-adjustment for CrCl <50. |

**HIV:**

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| .maxclinic | This is a MAX clinic patient who gets their primary medical and HIV care at the MAX clinic. They should follow up for hospital discharge visit at the MAX clinic, a walk-in clinic where the MAX team staff is available 9 AM-4:30 PM Monday to Friday. A medical provider is available from 1-4:30 PM Monday-Friday to see the patient.  No appointments are necessary. Please inform patient to go to the MAX clinic for a post hospital discharge visit.  Please ensure medications are given to patient in hand upon discharge or detailed plan for patient to get discharge medications is discussed with the MAX team. Thank you.  Place: MAX clinic (located in STD clinic, 11th floor NJB)  Time: MAX team walk-in clinic: Monday-Friday 9-4:30 PM (except holidays)  MAX clinic Medical Provider availability: Monday-Friday 1-4:30 PM (except holidays)  Phone: Allison Moore at 206 744 2284 or Courtney Large at 206 744 0041 |

**SOT:**

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| .highrisk | I spoke with \_ via \_ on \_ at \_ regarding the use of an organ from a CDC/PHS higher-than-standard risk donor. We discussed the potential risk of transmission of HIV, HCV, and HBV. All questions were answered. Prior to transplant, the patient understood and agreed to the use of an organ from a donor who was higher-than-standard risk due to:  [\_] high risk social situation  [\_] no available history  [\_] transfusion  [\_] injected drug use  [\_] incarceration  [\_] HD in preceding 12 months (increased risk for HCV only)  Per protocol, the patient should receive monitoring of the following labs:  Once between 1 - 3 months post transplant:  - Hep B surface Ab, surface Ag, core Ab, Hep B DNA quantitative by PCR  - HIV Ag and Ab, HIV RNA quantitative by PCR  - Hep C Ab, Hep C RNA quantitative by PCR  12 months post transplant:  - Hep B surface Ab, surface Ag, core Ab, Hep B DNA quantitative by PCR |