



**THE UNIVERSITY  
OF KANSAS HOSPITAL**

3901 Rainbow Boulevard  
Kansas City, Kansas 66160

Do not write in this box



PATIENT LABEL

**PHYSICIAN'S ORDER FORM**

DATE & TIME	#	<b>ORDERS</b> <b>DOFETILIDE (TIKOSYN®) PRE-INITIATION</b>
		<b>Legend:</b> <ul style="list-style-type: none"> <li>• Bullets indicate orders will be done. Draw one line through any orders that are not needed.</li> <li><input type="checkbox"/> Boxes are optional and must be checked to be considered an order.</li> </ul>
		Reference: <a href="http://www.tikosyn.com">www.tikosyn.com</a> , Tikosyn® Product Information (PI)
		Attending Physician: _____ Pager: _____ Resident Physician: _____ Pager: _____
		Allergies: _____ Patient Weight: _____ kg
	1.	<b>Admit to:</b> CVP, CTR or CIC (minimum of 3 days or 12 hours after conversion to NSR, whichever is greater).
	2.	<b>Nursing Communication:</b> <ul style="list-style-type: none"> <li>• Place on telemetry monitor.</li> <li>• Dofetilide (Tikosyn®) ordering is restricted to Tikosyn® Program Confirmed Cardiologist: Dr. _____</li> <li>• Only dofetilide (Tikosyn®) educated nurses may care for patient.</li> </ul>
	3.	<b>Lab:</b> <ul style="list-style-type: none"> <li>• BMP, Magnesium now (if not done within the last 24 hours), then daily</li> <li><input type="checkbox"/> Other: _____</li> </ul>
	4.	<b>Diagnostics:</b> Cardiology <ul style="list-style-type: none"> <li>• 12 Lead ECG (if not done within the last 24 hours)</li> </ul>
	5.	<b>Other:</b> All Class I or Class III antiarrhythmics have been held for at least 3 half-lives: <input type="checkbox"/> Yes <input type="checkbox"/> No* <i>* If no, indicate reason to proceed:</i>
	6.	Patient has not received amiodarone for 3 months, or blood concentration of amiodarone is less than 0.3 mcg/mL prior to giving dofetilide. <input type="checkbox"/> Yes <input type="checkbox"/> No* <i>* If no, indicate reason to proceed:</i>
	7.	Patient has been therapeutically anticoagulated for the past 3 weeks (INR>2) <input type="checkbox"/> Yes <input type="checkbox"/> No* <i>* If no, indicate reason to proceed:</i> <input type="checkbox"/> TEE ordered <input type="checkbox"/> Other reason:
	8.	<b>Medications:</b> Patient taking one of the following contraindicated medications: cimetidine, hydrochlorothiazide, ketoconazole, megestrol, prochlorperazine, trimethoprim, verapamil <input type="checkbox"/> Yes* <input type="checkbox"/> No <i>* If yes, indicate reason to proceed:</i> <input type="checkbox"/> Discontinue the following medications:
	9.	<b>Potassium Replacement</b> - prior to initial dofetilide dose if serum potassium is < 3.6 mmol/L and Creat is < 1.5 mg/dL): For serum potassium ≤ 2.5 mmol/L, give KCl 80mEq IV over 8 hours and 40 mEq po/NG x1 For serum potassium 2.5-3.1 mmol/L, give KCl 40mEq IV over 4 hours and give 40 mEq po/NG x1 For serum potassium 3.2-3.5 mmol/L, give KCl 40 mEq po/NG x1 For serum potassium 3.6-3.9 mmol/L, give KCl 20 mEq po/NG x1 - or - <input type="checkbox"/> KCl _____ mEq IV Run each 10mEq over 1 hour <input type="checkbox"/> KCl _____mEq po/NG x1 <input type="checkbox"/> Repeat BMP 1 hour after replacement dose administered
	10.	<b>Magnesium Replacement</b> - prior to initial dofetilide dose if serum magnesium is < 1.4 mg/dL and Creat < 1.5mg/dL: Magnesium sulfate 2gm IV over 2 hours - or - <input type="checkbox"/> Magnesium sulfate ____ gm IV. Run each gram over 1 hour <input type="checkbox"/> Repeat Magnesium 1 hour after replacement dose given
Physician Signature: _____		Pager: _____ Date: _____ Time: _____

**DOFETILIDE (TIKOSYN®) PRE-INITIATION**



**THE UNIVERSITY  
OF KANSAS HOSPITAL**

3901 Rainbow Boulevard  
Kansas City, Kansas 66160

Do not write in this box

PATIENT LABEL

**PHYSICIAN'S ORDER FORM**

DATE & TIME	#	ORDERS
<b>DOFETILIDE (TIKOSYN®) INITIATION/CONTINUATION ORDERS</b>		
		<b>INITIATION:</b>
		<b>Nursing Communication:</b> Dofetilide (Tikosyn®) education program confirmed prescriber <input type="checkbox"/> Yes <input type="checkbox"/> No
	1.	<b>HR:</b> _____ <b>Baseline QT/QTc:</b> _____ msec If baseline QTc > 440msec (500 msec in patients with ventricular conduction abnormalities, or 550 msec in patients with ventricular conduction abnormalities or ventricular pacing), indicate reason to proceed with administration: _____
	2.	<b>Notify Physician if:</b> <ul style="list-style-type: none"> <li>• Patient develops ventricular arrhythmias (torsade de pointes, sustained VT)</li> <li>• QTc increases beyond parameters indicated in the eMAR.</li> </ul>
	3.	<b>Laboratory:</b> STAT BMP and Magnesium if patient develops ventricular arrhythmia
	4.	<b>Diagnostics:</b> Cardiology <ul style="list-style-type: none"> <li>• Obtain 12 lead ECG two hours after first dose of dofetilide</li> <li>• Obtain 12 lead ECG two hours after all subsequent doses of dofetilide</li> </ul>
	5.	<b>Consults:</b> Consult Pharmacist for discharge education/material.
	6.	<b>Medications:</b> Daily Medications: <ul style="list-style-type: none"> <li>• CrCl: _____ mL/min (Dofetilide initiation orders written after 2100 will begin the following morning)</li> <li><input type="checkbox"/> Dofetilide 500mcg PO q12 hours, CrCl &gt;60mL/min</li> <li><input type="checkbox"/> Dofetilide 250mcg PO q12 hours, CrCl ≥ 40mL/min</li> <li><input type="checkbox"/> Dofetilide 125mcg PO q12 hours, CrCl ≥ 20mL/min</li> <li>• <u>Two hours after first dose of dofetilide:</u> Record QTc on eMar (include date and time). Notify cardiologist prior to giving next dose if: QTc increases by &gt; 15% or to &gt; 500 msec, or &gt; 550 msec in patients with ventricular conduction abnormalities or ventricular pacing.</li> <li>• <u>Two hours after all subsequent doses:</u> Record QTc on eMar (include date and time). Notify cardiologist prior to giving next dose if: QTc increases to &gt; 500 msec (&gt; 550 msec in patients with ventricular conduction abnormalities or ventricular pacing).</li> </ul>
	7.	<b>PRN:</b> STAT Magnesium Sulfate 1 gm over 5 minutes x 2 doses PRN ventricular arrhythmias
<b>CONTINUATION FROM HOME (PATIENT HAS RECEIVED A DOSE IN THE LAST 48 HOURS):</b>		
	1.	<b>Medications:</b> Daily Medications: CrCl: _____ mL/min <ul style="list-style-type: none"> <li><input type="checkbox"/> Dofetilide 500mcg PO q12 hours, CrCl &gt;60mL/min</li> <li><input type="checkbox"/> Dofetilide 250mcg PO q12 hours, CrCl ≥ 40mL/min</li> <li><input type="checkbox"/> Dofetilide 125mcg PO q12 hours, CrCl ≥ 20mL/min</li> </ul>

Physician Signature: \_\_\_\_\_ Pager: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**DOFETILIDE (TIKOSYN®) INITIATION/CONTINUATION ORDERS**

(Page 2 of 2)