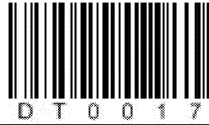
THE UNIVERSITY OF KANSAS HOSPITAL
3901 Rainbow Boulevard
Kansas City, Kansas 66160

**PHYSICIAN'S ORDER FORM**

Do not write in this box




PATIENT LABEL

| DATE & TIME | # | ORDERS |
|---|---|---|
| | | **TREPROSTINIL SQ (REMODULIN®) ORDER FORM**<br>**DIAGNOSIS PULMONARY HYPERTENSION** |
| | | **Legend:** • Bullets indicate orders will be done. Draw one line through any orders that are not needed.<br>☐ Boxes are optional and must be checked to be considered an order. |
| | | **Reference:** |
| | | **Attending Physician:**____________________ **Pager:**____________________________<br>**Resident Physician:** ____________________ **Pager:**____________________________ |
| | | **Allergies:**____________________________________ |
| | | **Treprostinil (Remodulin®) dosing weight** ___________kg (dosing weight does not change) |
| | 1. | **Level of Care:** ☐ Medicine/Surgery ☐ Telemetry/Intermediate<br>Patient Status: ☐ Inpatient Admission ☐ Observation Services ☐ Extended Recovery Services |
| | 2. | **Nursing Orders:**<br>• Change syringe as directed below<br>• For patients on Treprostinil already please change to Hospital supplied Treprostinil syringe upon admission |
| | 3. | **Notify Pulmonary Critical Care Physician if**:<br>• Treprostinil is interrupted, or if patient has<br>  • headache<br>  • chest pain<br>  • nausea/vomiting<br>  • anxiety/agitation<br>  • SBP 85<br>  • RR > 22<br>  • HR > 150 or < 60 |
| | 4. | **Consults:**<br>• Pulmonary Hypertension Service |
| | 5. | **Medications:**<br>Treprostinil is available in four different concentrations (1, 2.5, 5, and 10 mg/mL)<br>☐ **New Patient**<br>• Please mix 3mL of the _____ mg/mL (1 mg/mL) conc in a 3 mL CADD MS3 (217450) syringe<br>• Initial dose = __________ ng/kg/min (usually 1.25 ng/kg/min)<br>• Initial rate of syringe is ________ mL/hr<br>• Change syringe every _______hrs (72hrs)<br>☐ **Patient already on Treprostinil**<br>• Current dose _________ng/kg/min<br>• Mix 3 mL of the ________mg/mL (1, 2.5, 5 ,10 mg/mL) in the following syringe:<br>  • CADD MS3 3 mL (217450) syringe<br>• Patient's rate = _________mL/hr<br>• Change SQ syringe every _____ (normally q72h), unless the rate exceeds 3mL in 72 hour period |
| | | |

Physician Signature: ____________________________________ Pager: ____________ Date:______________ Time:______________