Trinity Health Grand Haven (THGH) Infusion Clinic
1309 Sheldon Road, Grand Haven MI 49417
Phone Number: 616-758-4994
Fax Number: 616-758-4657

MedroxyPROGESTERone (DEPO-PROVERA) ORDER SET

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes.

Order Date: __/____/____

Referral Status: ☐New Referral ☐Dose or Frequency Change ☐Renewal

Patient Name: _____
Date of Birth: ____/____/____
Weight: ____kg **Height:** ____cm
Allergies_____
☐ **NKA**

Primary Insurance: _____
Member ID: _____
Secondary Insurance: _____
Member ID: _____
Authorization number_____

	Date of last MedroxyPROGESTERone Injection (if known) _____
Lab	Prior to INITIAL administration of MedroxyPREGESTERone, there must be reasonable certainty that the patient is not pregnant (no symptoms of pregnancy) and the patient must meet at least any ONE of the following criteria: • The patient has not had intercourse since last normal menses • The patient has been correctly and consistently using a reliable method of contraception. • The patient is within 7 days from the first day of menstrual bleeding. • The patient is within 4 weeks postpartum (for nonlactating patients). • The patient is within the first 7 days' post abortion or miscarriage. • The patient is fully or nearly fully breastfeeding, amenorrhea, and less than 6 months postpartum. If criteria cannot be met, THGH will require a pregnancy screen prior to administration: ❑ Pregnancy Test Urine STAT Prior to **REPEAT** administration of MedroxyPROGESTERone, there must be reasonable certainty that the patient is not pregnant (no symptoms or signs of pregnancy) and the patient must be less than 14 weeks from their previous injection or be less than or equal to 1 week late for their repeat injection. If criteria cannot be met, THGH will require a pregnancy screen prior to administration: ❑ Pregnancy Test Urine STAT
Medications	❑ MedroxyPROGESTERone 150mg IM every 3 months x_____ doses (maximum 4 doses) ❑ MedroxyPROGESTERone 104mg Subcutaneously every 3 months x_____doses (maximum 4 doses) ❑ Other:_____
	☑ THGH Standard of Care Protocol for IV Access/Line Management and Emergency Medications for Allergic Reactions.

Provider Name: _____ Provider Signature: _____
Office Phone Number: _____ Office Fax Number: _____
Attending Physician Name: _____ (If ordering provider is an advanced practice practitioner, attending physician required)
Note: This order is valid for 12 months from date of physician signature.

The following Standard of Care Protocol has been approved for use in the Infusion Clinic at Trinity Health Grand Haven.

EMERGENCY MANAGEMENT OF ALLERGIC REACTIONS PROTOCOL	
Vital Signs	☑ Vital Signs: if patient has suspected Allergic Reaction: Every 5 Minutes until stable then every 15 Minutes until symptoms resolve. ☑ Pulse Oximetry: for suspected Allergic Reaction, initiate pulse oximetry monitoring until symptoms resolve.
Oxygen	☑ Oxygen PRN adjust to maintain O2 Sat greater than 90%
Cardio-pulmonary	☑ ECG STAT if complaint of chest pain or difficulty breathing ☑ Albuterol 2.5mg/3mL (0.003%) Nebulizer Treatment STAT PRN wheezing, bronchospasm, hypoxemia, dyspnea. Administer with oxygen. May repeat treatment Q10 Minutes for a total of 3 doses. ☑ SVN
Medications	☑ 0.9% Sodium Chloride 500mL IVPB STAT PRN hypotensive management (SBP less than 90mmHg or MAP less than 60). Infuse over 30 Minutes. Notify Physician for further orders. ☑ Acetaminophen (Tylenol) 650mg PO x1 dose PRN generalized pain, back pain, abdominal cramping, headache, or temperature greater than 100.5°F ☑ Famotidine (Pepcid) 20mg IV PUSH STAT x1 Dose PRN Allergic Reaction Severity Grade 3. Administer over 2 Minutes. Notify Physician for further orders ☑ Diphenhydramine (Benadryl) 50mg IV PUSH STAT x1 dose PRN Allergic Reaction Severity Grade 3. If patient has severe hypotension, administer after hypotensive episode is resolved. Use with caution in patient over 60 years of age or history of asthma. Notify Physician for further orders ☑ Diphenhydramine (Benadryl) 25mg IV PUSH STAT x1 dose PRN Allergic Reaction Severity Grade 2. Use with caution in patient over 60 years of age or history of asthma. Notify Physician for further orders ☑ Hydrocortisone 100mg IV PUSH STAT x1 PRN Allergic Reaction Severity Grade 3. Notify Physician for further orders ☑ Epinephrine (EPI-PEN) 0.3mg/0.3mL IM STAT PRN Allergic Reaction Severity Grades 3-4 or Anaphylaxis. May repeat Q15 Minutes x2 doses. Notify Physician for further orders *Based on the CoFAR Grading System for Systemic Allergic Reactions Version 3.0*

Per CMS survey and Certification group memo dated 8/11/2021, "the use of standing orders must be documented as an order in the patient's medical record and signed by the practitioner responsible for the care of the patient, but the timing of such documentation should not be a barrier to effective emergency response, timely and necessary care, or other patient safety advances.