Home Infusion Therapy Plan of Care

Skyrizi

Agency Info	**Elite Infusion Care- NPI 1760148456** **Fax- 424-349-0011 Phone- 714-519-6993** **Address: 1440 Harbor Blvd Ste 916 Fullerton, CA** **Email- Admin@Eliteinfusioncare.com**

Patient Name:		Date of birth	
Reason for Plan of Care	☐Initial ☐Change in Response to treatment ☐Refill Request ☐ MD order Change		
Advance Directive(s)	☐None ☐POA ☐Living Will ☐ Copy Obtained		
Plan of Care Development Participation	Patient Participated in the establishment/Maintenance of POC		
Service Location Type	☐ In- Home ☐ Physician Office/Clinic		
Ordering Physician		NPI	
Allergies	☐No Known Allergies ☐Other_____		
Diagnosis			
In Office Infusion Therapy Rejected by Patient	☐Yes ☐NO		
Start of Care		**# of Refills**	
Medication Order(s)			
Dose Frequency		**Rate of infusion (ML/HR)**	
Mode of Administration	-Medication May be administered via Gravity flow or IV Pump -Nurse may administer medication via Peripheral IV or Central Line		
Pre-medication #1			
Pre-medication #2			
Pre-Medication #3			
Additional Orders			

Anaphylaxis Protocol	•Epinephrine 1:1000 concentration 0.3 ML Sub Q up to 3 doses 15-20 Mins •Benadryl 50 MG IV Over 5-10 Min x1 Per Agency/or Pharmacy Protocol	1.STOP infusion. 2.Administer emergency meds as ordered. 3.Administer epinephrine as above and repeat dose if necessary. 4.Administer injectable diphenhydramine as above. If IV line is in place. 5.Initiate CPR (if needed). 6.Call EMS (activate the emergency medical system). 7.Monitor vital signs every 15 mins – elevate legs if hypotensive. 9.Notify prescriber and Director of Nurse/RN Supervisor and pharmacist

Physician Notification Parameters	Temperature	Blood Pressure	Heart Rate	Respirations	Glucose	Weight
	Temp <96.8 f > 100.4f	SBP <90 or > 150 Diastolic >90	HR < 55 or >110	Resp <12 or >24	glucose <65 >200	> 2 lb/day or >5 lb/week

Functional Limits	☐ None identified ☐ Other_____
Diet/Nutritional Needs	☐None Identified ☐ NPO ☐G-Tube ☐

	Other_____
Safety concerns	☐ None identified ☐Other_____
Nursing Orders	**Frequency: RN to Visit at week 0, 4 and week 8**
	Duration: Minimum of 1 hr -----1st dose RN will Monitor additional 30 minutes after infusion
	Nurse to Review Patient Medication History, Maintain Medication Profile, Physical, Mental and environment Assessment, Teaching and Education, Monitor response and adherence to treatment
Lab Collection	☐**Lab Collection-Not Ordered**
Test Ordered	☐CBC ☐CMP ☐BMP ☐CRP ☐ Other
Frequency	☐Weekly ☐Bi-Weekly☐ Other_____
Method of Collection	Nurse may collect using syringe or Vacuum Assistive device(Luer Lock Attachment), Nurse to collect Via vein-puncture or central line Access Device
IV insertion	Insert Peripheral IV or Access Port-a-Cath via Huber non coring needle PRN for infusion Medication administration
Nurse IV removal	•RN to Remove Peripheral or Huber Needle at the end of therapy or when needed to replace IV /May leave peripheral iv in for up to 96 hr. May leave in up to 7 days for patients with poor vascular access
Nursing Administration Instructions	***Complete all vaccines before starting Skyrizi** ***Do not administer SKYRIZI diluted solution concomitantly in the same intravenous line with other medicinal products** ***Nurse to Stay an additional 30 mins for 1st dose post infusion to monitor for adverse side effects**
Agency IV Flush Protocol	Normal Saline 0.9% -10ML IV before/After infusion and PRN for all VAD Maintenance **Final Flush** Heparin Sodium Flush 300 Units/ 3ML IV PRN for all Central Lines
Patient Specific Therapy Goals	☐Decrease or complete absence of symptoms related to Primary diagnosis ☐Prevent Progression of Disease Prevent Adverse Drug Reactions During Services ☐Maintenance of quality of Life
Discharge Plans	☐Life Long Treatment ☐ D/C when therapy complete ☐D/C when symptoms Stabilized ☐ D/C to Self injection therapy when loading doses complete
Equipment/ Supply Needs	IV Pole, IV insertion Supplies, Normal Saline Flushes, IV Pump, Administration Supplies

RN Print Name			**Date Signed**		
RN Signature					
Ordering/Physician		Signature		Date	
Medical Director	**Dr. Saba Haq,MD**	Signature	Dr Saba Haq	Date	

By Signing (Medical Director)I have reviewed the POC w/nursing staff to ensure POC meet 2 CCR § 74697 requirements and for the initiation of agency protocol orders. All Changes to Primary Medication will require orders from Ordering physician