

## Eptinezumab (Vyepti) Order Set

= Optional Order    • = Routine Order    (Cross out and initial **BULLETED ORDERS** that do not apply)

### ORDERS

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Diagnosis Code: (ICD-10) \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Weight: \_\_\_\_\_ (kg)

Allergies: \_\_\_\_\_

Avoid use in patients with recent cardiovascular or cerebrovascular ischemic events

#### PRE-MEDICATIONS-*Give prior to treatment*

When ordering a pretreatment medication, please select appropriate formulation.

- Acetaminophen - 650 mg oral times one
- diphenhydramine - 25 mg oral capsule – 25mg times one
- diphenhydramine - 25 mg, IV Push times one.
- Hydrocortisone - 100 mg, IV Push times one.
- Famotidine – 20 mg, oral. Tab. Give prior to treatment.
- Famotidine – 20 mg, IV Push. Injection. Give prior to treatment.

#### Eptinezumab (Vyepti)

- 100mg IVPB over 30 minutes every 3 months      Duration \_\_\_\_\_
- 300mg IVPB over 30 minutes every 3 months      Duration \_\_\_\_\_

- Use less than or equal to 0.22 micron filter tubing

**Monitoring parameter**-Monitor the patient for 30 minutes for hypersensitivity reaction after the first infusion

#### Treatment for Adverse Drug Reactions (for mild to moderate infusion reaction)

- Slow or stop infusion for 20 minutes
- Give:
  - Diphenhydramine (Benadryl) 25 mg slow IVP STAT (may repeat times 1)
  - Acetaminophen (Tylenol) 650 mg PO STAT, if not already given as a "premedication". (Maximum acetaminophen doses of 4000 mg in 24 hours from all combined sources.)
  - Methylprednisolone (Solu-Medrol) 125 mg IVP STAT
  - Albuterol (Albuterol HFA) 2 puff(s), inhale. As indicated, PRN shortness of breath or wheezing. Dose range 1-2 puffs.
- Place O<sub>2</sub> PRN at 4 – 6 liters per nasal cannula STAT
- Vital signs with PO<sub>2</sub> every 5 minutes until stable
- Notify the physician of reaction. Request further orders as indicated.
- Complete adverse drug reaction PowerForm and document in the allergy profile for all drug reactions.

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Name and Credentials (please print): \_\_\_\_\_ Time: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

