SOMC Cancer Center & Infusion
Ph: (740) 356-7490
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Ertapenem (INVANZ) Order Form

PATIENT & PRESCRIBER INFORMATION

Patient Name: _____ DOB: _____ Phone: (H) _____ (C) _____

Patient Address: _____

Ht.: _____ Wt.: _____ ☐lbs. ☐kg. Allergies: _____

Prescriber Name/Title: _____ Address: _____

Phone: _____ Fax: _____ Prescriber NPI #: _____

REQUIRED: **Indication (must meet pre-approved criteria), most recent H&P, medication list is required unless the patient is established with SOMC and supporting clinical notes. Supporting clinical notes should include rationale for indication; any past tried and/or failed therapies, intolerances, outcomes, or contraindications to conventional therapy-including why oral antibiotics are not being used if patient has a functioning gut.**

Required for Protected antibiotic.
Current Micro Data (culture/sensitivity): _____
Lab Results: Creatinine _____mg/dL Date obtained _____

CLINICAL INFORMATION, & PRESCRIPTION

Ertapenem (INVANZ)

☒ In the event of an adverse reaction, line maintenance/flushes, or O2 are required, the SOMC AIC established protocols will be utilized.

☒ 0.9% NaCl 250 ml primary at KVO during infusion, and flush line during observation period.

AND

Diagnosis Description: _____

Dose

☐**Ertapenem (Invanz) 1 gram** in 50 ml 0.9% NaCl IVBP over 30 minutes Q24H infusion for CrCl ≥ 30ml/min

OR

☐**Ertapenem (Invanz) 0.5 gram** in 50 ml 0.9% NaCl IVBP over 30 minutes Q24H infusion CrCl < 30ml/min

Total # days:_____ Start date: _____ Stop date: _____

Weekly Lab Orders

- ☐ CBC w/diff
- ☐ Creatinine
- ☐ BMP
- ☐ CMP
- ☐ CRP
- ☐ ESR
- ☐ None
- ☐ Other _____

PROVIDER:	DATE:	TIME:	SIGNATURE:

Southern Ohio Medical Center
Very Good things are happening here

ERTAPENEM

Created: 06/21/23	P & T Comm.
Reviewed & Approved	06/21/23
Next Review Date	06/21/25
Version	V06212023.0