Conveniently Located in East Syracuse, Onondaga Hill & Auburn
Main Office Phone 315-472-7504
Nurse Navigator Phone 315-506-2469
Main Fax 315-634-5168

Desmopressin (DDVAP/Stimate) Non-Oncology Treatment Order Set

1. Patient Name: _____

2. DOB: _____ **Height (inches):** _____ **Weight (lbs):** _____

3. Diagnosis:

[ ] Primary ICD-10 Code: _____ Diagnosis description: _____
[ ] Other ICD-10 Code: _____ Diagnosis description: _____

HOACNY will obtain authorization for drug administration prior to scheduled infusion. If HOACNY is unable to obtain insurance authorization due to this medication not being in alignment with the insurance plan's medical policy, referring office will be notified and HOACNY will not be able to administer the medication.

4. Pre-medications:

[ ] Other Pre-medication: _____
[ ] No Pre-medications indicated

5. Drug Order:

Desmopressin (DDAVP/Stimate) Ok to substitute with generic/biosimilar
[ ] 0.3mcg/kg IV one time
[ ] (1.5mg/ml concentration), 300mcg/50kg 1 spray each nostril
[ ] Special Instructions: _____
[ ] New to Therapy
[ ] Continuing therapy: Last Dose Received _____ Next Dose Due _____

HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral

6. Infusion Lab Requirements:

[ ] CBC & CMP within 30 days prior to infusion
[ ] Other: _____
[ ] No lab monitoring indicated

HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.
The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

7. **Required Baseline Lab/Testing completed**:

[ ] CBC, date: _____ [ ] CMP, date: _____[ ] Factor VIII activity level, date: _____
[ ] VonWillebrand Factor, date: _____ [ ] Other: _____

8. **Patient Assistance & REMS Program Enrollment**

[ ] Yes, patient has been enrolled in _____ program. (Provide Copy Enrollment Forms)
[ ] No, patient has not been enrolled in any programs.

Physician's Name: _____ **Phone:** _____
Physician's Signature: _____**Date:** _____

(This drug administration order form is valid for 12 months)