McLeod Health

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Daptomycin (Cubicin) Treatment Plan

Patient Name: ____ DOB: _______________________

Height (cm): _____________________ Weight (kg): ________________ Allergies: ___________________

Serum creatinine (mg/dL): _______ Date of lab: _____________ CrCl (mL/min): __________ or ☐ ESRD on scheduled HD

Dosing Weight: _______ kg

To calculate ideal body weight (IBW): Males: IBW = 50 kg + 2.3 kg for each inch over 5 feet
Females: IBW = 45.5 kg + 2.3 kg for each inch over 5 feet

If total body weight (TBW) is ≤ IBW, then use *total body weight as the dosing weight*
If TBW > 120% IBW, use adjusted body weight (AdjBW) as dosing weight: AdjBW = [(TBW – IBW) x 0.4] + IBW

Diagnosis (select one ICD-10 code):

☐ A49.02 Methicillin-resistant *Staphylococcus aureus* infection, unspecified site

☐ L08.9 Local infection of the skin and subcutaneous tissue, unspecified

☐ A49.1 Streptococcal infection, unspecified site ☐ M86.10 Other acute osteomyelitis, unspecified site

☐ M86.60 Other chronic osteomyelitis, unspecified site ☐ R78.81 Bacteremia

☐ Other ICD 10 Code: __________________ Diagnosis Description: _________________________________

Drug Orders: The physician will select appropriate dosing based on indication

- Heparin and NS or D5W flushes as needed to maintain line
- Related items and/or supplies needed to administer medication and complete prescribed therapy
- Daptomycin (Cubicin) (J0878) per 50 mL NS IV to infuse over 30 minutes
- Dose:
  - ☐ Daptomycin 6 mg/kg (pharmacy to round to nearest 250 mg)
  - ☐ Daptomycin 8 mg/kg (pharmacy to round to nearest 250 mg)
  - ☐ Daptomycin 10 mg/kg (pharmacy to round to nearest 250 mg)
  - ☐ Other dose: ______________ mg
- Frequency:
  - ☐ CrCl ≥ 30 mL/min: Every 24 hours
  - ☐ CrCl < 30 mL/min (but not on scheduled hemodialysis): Every 48 hours
  - ☐ Other dosing schedule: _________________
- Duration:
  - ☐ 6 weeks (end date: ____________)

Approved: 02/2022

☐ Other duration: _________ (end date: ____________)

Lab Orders:

• Complete blood count (CBC) with differential, Basic metabolic panel (BMP), Creatinine phosphokinase (CPK), and C-reactive protein (CRP) weekly with reported results

☐ Other: ____

Standing Orders:

• Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: ____ **Date:** ___________________________

Physician Name: ____ **Phone:** __________________________

Insurance/Authorization Information:

Insurance Type: ____

Insurance Authorization Reference Number: ____

Date Obtained: ____________________________ Authorization Valid Until: _________________________

Additional Notes: ____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Cheraw: 843-320-3469 (Fax)

843-320-5557 (Phone)