McLeod Health

Place Sticker Here

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: _____)

☐ 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.

Dillon: 843-487-1491 (Fax)

843-487-1334 (Phone)