



**Atrium Health Infusion
Center**

Referral Status:	<input type="checkbox"/> New Start <input type="checkbox"/> Order Change <input type="checkbox"/> Renewal
Preferred Location:	<input type="checkbox"/> Atrium Health Infusion Center Concord Fax: 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Pineville Fax: 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Southpark Fax: 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Huntersville Fax: 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Kenilworth, a facility of CMC Fax: 704-512-5390 <input type="checkbox"/> Atrium Health Infusion Center Abbey Place, a facility of CMC Fax: 704-512-5390 <input type="checkbox"/> Atrium Health Infusion Center Cabarrus, a facility of CMC Fax: 704-512-5390

Vistide® (cidofivir) Infusion Order (Revised 11/7/2025)

All orders with a √ will be placed.

Patient Demographics:		
Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:
Allergies: (please list all allergies or attach list)		
<input type="checkbox"/> NKDA		
Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)		
<input type="checkbox"/> ICD-10:		<input type="checkbox"/> Other:
Required Documentation: (required prior to scheduling)		
Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:	
Copy of Insurance Card (front and back)		
Most Recent Labs (must include labs pertinent to medication ordered)	<input type="checkbox"/> No Washout Needed	
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion:	
Complete Medication List - Include all tried and failed meds	Next infusion due date:	
Diagnostic Studies Pertinent to Medication Ordered	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.	
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nursing Communication:		
<input checked="" type="checkbox"/> Start PIV/Access CVC and flush device per approved Atrium Health protocol.		
<input checked="" type="checkbox"/> Obtain vital signs PRE-treatment and POST-treatment. Obtain vital signs PRN during treatment.		
<input checked="" type="checkbox"/> Monitor patient for signs of reaction for 30mins AFTER completion of 1st infusion and subsequent infusions PRN IF previous signs of reaction observed.		
Pre-Medications:		
<input type="checkbox"/> Acetaminophen (Tylenol) 650mg PO ONCE		
<input type="checkbox"/> Diphenhydramine (Benadryl) 25mg PO ONCE		
<input type="checkbox"/> Diphenhydramine (Benadryl) 25mg IV ONCE		
<input type="checkbox"/> Loratadine (Claritin) 10mg PO ONCE		
<input type="checkbox"/> Methylprednisolone Sodium Succinate (Solu-Medrol) 125mg IV ONCE		
Hydration:		
<input type="checkbox"/> Pre-hydration: Sodium Chloride 0.9% 1000mL IV over 60 minutes every 2 weeks		
<input type="checkbox"/> Post-hydration: Sodium Chloride 0.9% 1000mL IV over 60 minutes every 2 weeks		
Infusion Therapy:		
<input type="checkbox"/> Cidofivir (Vistide) 0.5mg/kg IV at 200mL/hr (over 60 minutes) every 2 weeks		
Supportive Care Medications:		
<input checked="" type="checkbox"/> Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.		
<input checked="" type="checkbox"/> Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.		
<input checked="" type="checkbox"/> Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.		
Hypersensitivity Protocol:		
<input checked="" type="checkbox"/> Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.		
Prescriber Information:		
Provider Name:	Phone:	Fax:
Practice Name:	NPI:	
Address:	Office Contact:	
City, State, Zip:	Office Contact Phone Number:	
Physician Signature: (Order expires 12 months from date of signature) No Stamp Signatures Accepted		
Signature:	Date:	