(place patient label here)

Patient Name:_____

BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PROVIDER ORDERS

Order Set Directions:
- **(√)- Check orders to activate; Orders with pre-checked box ☑ will be followed unless lined out.**
- **Initial each place in the pre-printed order set where changes such as additions, deletions or line outs have been made**
- **Initial each page and Sign/Date/Time last page**

Diagnosis: _____
Allergies with reaction type:_____

INTEGRILIN (eptifibatide) **Version 4 8/9/2012**
RX = EPT

1. Loading Dose: IV push over 1 to 2 minutes

   180 mcg/kg (2 mg/ml) (Patient weight _____ kg)
   Maximum bolus amount is 11.3 ml (22.6mg) for >121 kg

2. Second loading dose:
   Give 10 min after first dose.
   Repeat dose calculated in #1.

3. Maintenance Dose: (0.75 mg/ml) at 2 mcg/kg/min maximum drip 15 mg/hr (20 ml/hr)
   If GFR <50 min then run @ 1mcg/kg/min (max 7.5 mg/hr)

PATIENT WEIGHT (KG)	**BOLUS VOLUME (2 mg/ml)**	**INFUSION RATE (0.75 mg/ml)**
60-65	5.6 mL	10 mL/h
66-71	6.2	11
72-78	6.8	12
79-84	7.3	13
85-90	7.9	14
91-96	8.5	15

4. Do not administer through the same IV line as furosemide.

5. INFUSE X _____ HOURS.

6. Other dose _____

   _____

   _____

Provider Signature:_____Date:_____Time:_____