Pertussis PEP Medication Contraindications and Precautions Checklist

Contraindications to use azithromycin **(the first line antibiotic for pertussis PEP):**	**Yes**	**No**
If any box in this section is checked Yes and the client is < 2 months old, notify the authorizing physician. If any box in this section is checked Yes and the client is ≥ 2 months old, do not provide azithromycin. Skip Section *Medications to avoid when used with azithromycin* and proceed to *Section Contraindications to use TMP-SMZ*.		
Does the client have an allergy to azithromycin, clarithromycin, dirithromycin, erythromycin, or telithromycin?	☐	☐
Does the client have a personal or family history of QT prolongation, torsades de pointes, ventricular arrhythmias, or bradycardia?	☐	☐
Does the client have/ever had recent myocardial infarction, congestive heart failure, electrolyte abnormality, myasthenia gravis, recent antibiotic-associated colitis history, hepatic impairment, jaundice, or renal impairment?	☐	☐
Does the client take (or has recently taken) any of the following contraindicated medications?	☐	☐
BCG live intravesical	☐	☐
Dronedarone (Multaq)	☐	☐
Pimozide (Orap)	☐	☐
Medications to avoid when used with azithromycin **(the first line antibiotic for pertussis PEP):**	**Yes**	**No**
If any box in this section is checked Yes, notify the authorizing physician for direction.		
Antiarrhythmics such as amiodarone (Cordarone, Pacerone), disopyramide (Norpace), dofetilide (Tikosyn), ibutilide (Corvert), procainamide (Procanbid), quinidine, and sotalol (Betapace, Sorine)	☐	☐
Anticoagulants such as warfarin (Coumadin, Jantoven), enoxaparin (Lovenox), heparin	☐	☐
Carbamazepine (Tegretol)	☐	☐
Cyclosporine (Neoral, Sandimmune)	☐	☐
Digoxin (Lanoxin)	☐	☐
Ergot medications for migraine such as dihydroergotamine (D.H.E. 45, Migranal), ergotamine (Ergomar, Cafergot, Bellargal)	☐	☐
Ondansetron (Zofran)	☐	☐
Phenothiazines (chlorpromazine, fluphenazine, perphenazine, prochlorperazine, promethazine, thioridazine, trifluoperazine)	☐	☐
Phenytoin (Dilantin)	☐	☐
Tricyclic antidepressants such as amitriptyline (Elavil), amoxapine, desipramine (Norpramin), doxepin (Sinequan), imipramine (Tofranil), nortriptyline (Pamelor), protriptyline (Vivactil), trimipramine (Surmontil)	☐	☐
Does the client use another medication(s) not listed that could interact with azithromycin and should be avoided? **List medication(s):**_____ **NOTE: The nurse should seek out /consult with a trusted drug information source (e.g., DSHS Library access to "Facts and Comparisons," DSHS pharmacist, authorizing physician) to verify possible medication interactions and document in the client's record.** **Document drug information resource used to determine possible medication interactions and the date the resource was accessed:** _____	☐	☐

If all answers in the sections above are No, have client review and sign *Client Attestation* below.
Provide azithromycin for pertussis PEP and the *Azithromycin for Pertussis PEP Fact Sheet* to the client only if *Client Attestation* is signed.
Record required information in *Azithromycin Medication Information Box* below.

Client Attestation

1. I agree that the person named below meets at least one of the following criteria to receive pertussis PEP from DSHS:
   - Unable to access medical care within a reasonable time period to prevent disease spread.
   - Lack financial resources to pay for medical care or PEP.
   - A medical provider has given guidance/recommendations for pertussis PEP that vary from DSHS and CDC recommendations.
2. I agree that the person named below will receive azithromycin for pertussis PEP.
3. I received or was offered a copy of the *Pertussis Information Sheet* and the *Azithromycin for Pertussis PEP Fact Sheet.*
4. I know the risks of pertussis.
5. I know the benefits and risks of azithromycin.
6. I have had a chance to ask questions about pertussis and azithromycin.
7. I know that the person named below will receive azithromycin to put in his/her body to prevent pertussis.
8. I am an adult who can legally consent for the person named below to receive azithromycin.

I freely and voluntarily give my signed permission for this pertussis PEP.

Name of person to receive pertussis PEP:_____

Signature of person to receive pertussis PEP or person authorized to make the request (parent or guardian):

_____ **Date:** _____

Testimonio del cliente

1. Atestiguo que la persona cuyo nombre aparece abajo cubre al menos uno de los siguientes criterios necesarios para recibir la profilaxis posexposición (PEP) del DSHS:
   - La persona no puede acceder a servicios de atención médica en un plazo razonable para evitar que la enfermedad se propague.
   - La persona no tiene los recursos financieros necesarios para pagar los servicios de atención médica o la PEP.
   - Un proveedor de servicios médicos ha dado orientación o recomendaciones para la PEP por pertussis, los cuales difieren de las recomendaciones del DSHS y los CDC.
2. Atestiguo que la persona cuyo nombre aparece abajo recibirá azitromicina para la PEP por pertussis.
3. Recibí o me ofrecieron una copia de la Declaración informativa sobre la pertussis y la Hoja informativa sobre la azitromicina para la PEP por pertussis.
4. Conozco los riesgos de la pertussis.
5. Conozco los beneficios y los riesgos de la azitromicina.
6. He tenido oportunidad de hacer preguntas sobre la pertussis y la azitromicina.
7. Sé que la persona cuyo nombre aparece abajo recibirá azitromicina para que esta entre en su cuerpo para prevenir la pertussis.
8. Soy un adulto y legalmente puedo dar el consentimiento para que la persona cuyo nombre aparece abajo reciba azitromicina.

Libre y voluntariamente doy mi permiso firmado para la PEP por pertussis.

Nombre de la persona que recibirá la PEP por pertussis: _____

Firma de la persona que recibirá la PEP por pertussis o la persona autorizada para hacer la petición (padre, madre o tutor(a)):

_____ Fecha: _____

AZITHROMYCIN MEDICATION INFORMATION BOX

Date medication given to client:_____

Name and Strength of drug:_____

Directions for use:_____ Name of manufactuer:_____

Quantity:_____ Expiration date:_____ Lot number:_____

Authorizing Physician:_____

☐ Check box to verify *Azithromycin for Pertussis PEP Fact Sheet* provided

Authorized Licensed Nurse Name:_____

Authorized Licensed Nurse Signature:_____

***Contraindications to use TMP-SMZ* (the alternative antibiotic for pertussis PEP):**	**Yes**	**No**
If any box in this section is checked Yes, do not provide TMP-SMZ. Notify the authorizing physician.		
Is the client <2 months old?	☐	☐
Does the client have an allergy to TMP-SMZ, Bactrim, Septra, trimethoprim, sulfamethoxazole, hydrochlorothiazide (HCTZ), sulfonylureas, any sulfa drug, or sulfonamides?	☐	☐
Does the client have/ever had liver or kidney disease, hyperkalemia, porphyria, lupus erythematosus, asthma, chronic alcohol use, recent antibiotic-associated colitis history, or glucose-6-phosphate dehydrogenase (G-6-PD) deficiency?	☐	☐
If the client is female, is she pregnant, trying to become pregnant, or breast-feeding?	☐	☐
Does the client take (or has recently taken) any of the following contraindicated medications?	☐	☐
BCG live intravesical	☐	☐
Dofetilide (Tikosyn)	☐	☐
Methenamine (Urex, Hiprex)	☐	☐
***Medications to avoid when used with TMP-SMZ* (the alternative antibiotic for pertussis PEP):**	**Yes**	**No**
If any box in this section is checked Yes, notify the authorizing physician for direction.		
Anticoagulants such as warfarin (Coumadin, Jantoven), enoxaparin (Lovenox), heparin	☐	☐
Amiodarone (Cordarone, Pacerone)	☐	☐
Digoxin (Lanoxin)	☐	☐
Leucovorin	☐	☐
Medications that can increase serum potassium levels such as ACE inhibitors, angiotensin receptor blockers, potassium-sparing diuretics, potassium supplements, and spironolactone	☐	☐
Methotrexate	☐	☐
Oral diabetes medications such as sulfonylureas (Glipizide, Glimepiride), thioglitazones (Actos, Avandia)	☐	☐
Phenytoin (Dilantin)	☐	☐
Pyrimethamine (Daraprim)	☐	☐
Thiazide diuretics (HCTZ)	☐	☐
Topical Retin A, tretinoin	☐	☐
Does the client use another medication(s) not listed that could interact with TMP-SMZ and should be avoided? **List medication(s):**_____ _____ **NOTE: The nurse should seek out /consult with a trusted drug information source (e.g., DSHS Library access to "Facts and Comparisons," DSHS pharmacist, authorizing physician) to verify possible medication interactions and document in the client's record.** **Document drug information resource used to determine posssible medication interactions and the date the resource was accessed:**_____ _____	☐	☐

If all answers in the sections above are No, have client review and sign *Client Attestation* below.
Provide TMP-SMZ for pertussis PEP and the *TMP-SMZ for Pertussis PEP Fact Sheet* to the client only if *Client Attestation* is signed.
Record required information in *TMP-SMZ Medication Information Box* below.

Client Attestation

1. I agree that the person named below meets at least one of the following criteria to receive pertussis PEP from DSHS:
   - Unable to access medical care within a reasonable time period to prevent disease spread.
   - Lack financial resources to pay for medical care or PEP.
   - A medical provider has given guidance/recommendations for pertussis PEP that vary from DSHS and CDC recommendations.
2. I agree that the person named below will receive TMP-SMZ for pertussis PEP.
3. I received or was offered a copy of the *Pertussis Information Sheet* and the *TMP-SMZ for Pertussis PEP Fact Sheet*.
4. I know the risks of pertussis.
5. I know the benefits and risks of TMP-SMZ.
6. I have had a chance to ask questions about pertussis and TMP-SMZ.
7. I know that the person named below will receive TMP-SMZ to put in his/her body to prevent pertussis.
8. I am an adult who can legally consent for the person named below to receive TMP-SMZ.

I freely and voluntarily give my signed permission for this pertussis PEP.

Name of person to receive pertussis PEP:_____

Signature of person to receive pertussis PEP or person authorized to make the request (parent or guardian):
_____ **Date:** _____

Testimonio del cliente

1. Atestiguo que la persona cuyo nombre aparece abajo cubre al menos uno de los siguientes criterios necesarios para recibir la profilaxis posexposición (PEP) del DSHS:
   - La persona no puede acceder a servicios de atención médica en un plazo razonable para evitar que la enfermedad se propague.
   - La persona no tiene los recursos financieros necesarios para pagar los servicios de atención médica o la PEP.
   - Un proveedor de servicios médicos ha dado orientación o recomendaciones para la PEP por pertussis, los cuales difieren de las recomendaciones del DSHS y los CDC.
2. Atestiguo que la persona cuyo nombre aparece abajo recibirá TMP-SMZ para la PEP por pertussis.
3. Recibí o me ofrecieron una copia de la Declaración informativa sobre la pertussis y la Hoja informativa sobre la TMP-SMZ para la PEP por pertussis.
4. Conozco los riesgos de la pertussis.
5. Conozco los beneficios y los riesgos de la TMP-SMZ.
6. He tenido oportunidad de hacer preguntas sobre la pertussis y la TMP-SMZ.
7. Sé que la persona cuyo nombre aparece abajo recibirá TMP-SMZ para que esta entre en su cuerpo para prevenir la pertussis.
8. Soy un adulto y legalmente puedo dar el consentimiento para que la persona cuyo nombre aparece abajo reciba TMP-SMZ.

Libre y voluntariamente doy mi permiso firmado para la PEP por pertussis.

Nombre de la persona que recibirá la PEP por pertussis: _____

Firma de la persona que recibirá la PEP por pertussis o la persona autorizada para hacer la petición (padre, madre o tutor(a)):
_____ **Fecha:** _____

TMP-SMZ MEDICATION INFORMATION BOX

Date medication given to client:_____

Name and Strength of drug:_____

Directions for use:_____ Name of manufacturer:_____

Quantity:_____ Expiration date:_____ Lot number:_____

Authorizing Physician:_____

☐ Check box to verify *TMP-SMZ for Pertussis PEP Fact Sheet Provided*

Authorized Licensed Nurse Name:_____

Authorized Licensed Nurse Signature:_____