KVH
Klickitat Valley Health

Outpatient Penicillin Allergy Challenge Order Set

Phone: 509-772-2695 Fax: 509-773-3354

General

Patient Name _____ DOB _____ Height _____ Weight _____ Phone #_____

Order Start Date _____ Order Expiration Date _____

Allergies: _____

Guidelines for Ordering:

1. Send **FACE SHEET** and **H&P** or most recent chart note.
2. Provider to evaluate patient per KVH Penicillin Allergy Challenge Protocol with PEN-FAST tool.

DIAGNOSIS CODE:

☒ Z88.0 Allergy Status to Penicillin

Medical Necessity *(Completion required to schedule testing)*:

1. **Reason for Challenge (Indication)** Please indicate why an oral penicillin challenge is medically necessary for this patient:

☐ Reported penicillin allergy with unclear or remote history
☐ Suspected penicillin allergy without objective confirmation
☐ Conflicting prior allergy testing or documentation
☐ Need to verify tolerance due to anticipated antibiotic need
☐ Other (please specify): _____

2. **Why Alternative Testing Is Insufficient** Why are skin testing and/or serum IgE testing not adequate or appropriate in this case?

☐ Prior skin and/or IgE testing was negative or inconclusive
☐ Skin or IgE testing is not clinically indicated based on history
☐ Testing does not reliably predict clinical tolerance in this scenario
☐ Other (please specify): _____

3. **Need for Supervised Oral Challenge** Why must this challenge be performed in a supervised medical setting?

☐ Risk of allergic reaction requiring monitoring or intervention
☐ History suggests potential for reaction despite low risk
☐ Patient safety concerns require medical observation
☐ Other (please specify): _____

4. **Expected Impact on Medical Management** This challenge is expected to determine whether penicillin can be safely prescribed, allow removal of the penicillin allergy from the medical record, and expand appropriate antibiotic treatment options.

☐ Additional expected impacts (if applicable): _____

Patient Name:
DOB:

Nursing/Medication Orders

☒ ORAL PENICILLIN CHALLENGE TEST:

Step 1: Obtain baseline vital signs. Administer amoxicillin 50 mg PO. Monitor for signs/symptoms of an allergic reaction and repeat vital signs at 30 minutes following administration.

Step 2: If the patient has no reaction after 30 min, administer amoxicillin 500 mg PO. Monitor for signs/ symptoms of an allergic reaction and repeat vital signs at 60 minutes following administration.

Step 3: If the patient has no reaction after 60 min, remove the penicillin allergy from the patient's chart.

IF ANAPHYLACTIC REACTION OCCURS

☒ Notify provider and/or Hospitalist on duty if afterhours, administer oxygen prn, administer Benadryl 50 mg IV or IM once STAT, administer Epinephrine (1:1000) 0.5mg IM once STAT, possible admission to emergency department for further evaluation/treatment.

Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patent identified on this form.

I hold an active, unrestricted license to practice medicine in _____ *(specify state)*

My physician license number is # _____ and I am acting within my scope of practice and authorized by law to order infusion of the medication described above for the patient identified on this form.

Provider Signature: _____ **Date** _____

Printed name: _____ **Phone:** _____ **Fax:** _____

KVH Provider Co-signature:

**Required for all external orders*

Provider Signature: _____ **Date** _____

Printed name: _____

Patient Name:
DOB: