Texas Department of State Health Services Standing Delegation Orders: Pertussis Post exposure Prophylaxis Clinical Services Provided by Registered Nurses and Licensed Vocational Nurses, FY2016-17

The purpose of this document is to provide authority for specific acts of Pertussis post exposure prophylaxis (PEP) clinical services under authority of Rule Title 22, Texas Administrative Code §193.2, Standing Delegation Orders.

Standing delegation orders (SDOs) and standing medical orders (SMOs) are written instructions, orders, rules, regulations or procedures prepared by a physician. SDOs provide authority and a plan for use with patients presenting themselves, prior to being examined or evaluated by a physician. SMOs provide authority and direction for the performance of certain prescribed acts for patients who have been examined or evaluated by a physician. SDOs and SMOs are distinct from specific orders written for a particular patient.

This order is to authorize licensed nurses working in Texas Department of State Health Services (DSHS) Health Service Regions.

Table of Contents

ATTACHMENT 7: *TMP-SMZ for Pertussis PEP Fact Sheet* (DSHS Immunization Branch Stock No. 11-14178– revised 06/2015)

ATTACHMENT 8: *Pediatric Dosage Guidelines for Azithromycin Oral Suspension*

Standing Delegation Orders

A. Definitions

1. Authorized Licensed Nurse: an employee or contractor of the Texas Department of State Health Services who holds a valid Texas Nursing license and who has met the requirements of and signed this SDO.

2. Authorizing Physician: a physician licensed by the Texas Medical Board and employed by or contracted to the Department of State Health Services who signs this SDO.

B. Method Used for Development, Approval, and Revision

This SDO and the relevant attachments shall be:

1. Developed and written by the DSHS Regional Medical Director.

2. Reviewed by and signed at least annually by the authorizing physician.

3. Revised as deemed necessary by the DSHS Regional Medical Directors.

C. Level of Experience, Training, Competence, and Education Required

To carry out acts under this SDO, an authorized licensed nurse must:

1. Be an employee or contractor of the Texas Department of State Health Services.

2. Be licensed to practice by the Texas Board of Nursing.

3. Be certified in Basic Life Support.

4. Have reviewed, are familiar with, and able to access the following:
   a. Recommended Antimicrobial Agents for the Treatment and Post exposure Prophylaxis of Pertussis 2005 CDC Guidelines. MMWR 2005; 54 (RR14), available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5414a1.htm?s_cid=rr5414a1_e
   - The Pink Book: Epidemiology and Prevention of Vaccine-Preventable Diseases 13th Edition (April, 2015), chapter 16 on Pertussis, available at: http://www.cdc.gov/vaccines/pubs/pinkbook/pert.html

5. Have completed training on:
   b. Mixing of azithromycin oral suspension for pediatric dosing
   c. The rationale for and the effects of PEP medications and treatments
   d. DSHS Immunization Branch Pertussis PEP forms that must be used and completed by the authorized licensed nurse.
      i. ATTACHMENT 2: *Pertussis Information Sheet* (DSHS Immunization Branch Stock No. 11-

14175)

ii. ATTACHMENT 3: *Pertussis PEP Eligibility Criteria Checklist* (DSHS Immunization Branch Stock No. F11-14177 - revised 08/2014)

iii. ATTACHMENT 4: *Pertussis PEP Client Evaluation Form* (DSHS Immunization Branch Stock No. F11-14174 - revised 03/2014)

iv. ATTACHMENT 5: *Pertussis PEP Medication Contraindications and Precautions Checklist* (DSHS Immunization Branch Stock No. F11-14176 – revised 06/2015)

v. ATTACHMENT 6: *Azithromycin for Pertussis PEP Fact Sheet* (DSHS Immunization Branch Stock No. 11-14179 - revised 08/2014)

e. Forms are available at: www.immunizetexasorderform.com

6. Prior to providing Pertussis PEP services under this SDO, the nurse must have undergone an initial or continuing evaluation of competence relevant to pertussis PEP clinical services within the preceding 12 months:

   a. Initial evaluation of competence is performed by the nurse's supervisor and consists of verification that the authorized licensed nurse possesses a valid nursing license, a post-evaluation of initial training, and observation of the required clinical skills.

      If the nurse's supervisor is not a licensed clinician, a licensed nurse or authorizing physician responsible to oversee the clinical practice of the authorized licensed nurse shall be responsible for observation of the required clinical skills.

   b. Continuing evaluation of competence is performed annually by the nurse's supervisor, or clinical designee, and consists of verification that the authorized licensed nurse possesses a valid nursing license, an annual Pertussis PEP review with a post-test evaluation, and periodic observation of the required clinical skills.

      If the nurse's supervisor is not a licensed clinician, a licensed nurse or authorizing physician responsible to oversee the clinical practice of the authorized licensed nurse shall be responsible for observation of the required clinical skills.

7. Prior to providing Pertussis PEP services under this SDO, the nurse must have reviewed and signed this SDO and the ***Attestation of Authorized Licensed Nurse***, (Attachment 1) within the preceding 12 months.

D. Method of Maintaining a Written Record of Authorized Licensed Nurses

A record of the authorized licensed nurses who complete the required training, demonstrated competence, and signed the SDO shall be documented and maintained by the nurse's supervisor in the Health Service Region office. They physician-signed SDOs will be electronically scanned and deposited into the RLHS SharePoint site, Standing Delegation Orders folder, along with a nurse-signed ***Attestation of Authorized Licensed Nurse***, (Attachment 1) for each nurse who is authorized to perform and has signed this SDO.

E. Authorized Delegated Acts

Authorized licensed nurses may evaluate and provide pertussis PEP clinical services under this SDO to clients who are identified by DSHS through disease reporting and contact investigation as close or high-risk contacts to a pertussis case and who are then evaluated at a DSHS regional clinic.

F. Procedures and Requirements to be Followed by Authorized Licensed Nurses

Adhere to Standard Precautions infection control precautions when participating in clinical services. (Available at: http://www.cdc.gov/HAI/settings/outpatient/outpatient-care-gl-standared-precautions.html) Hand hygiene should always be performed between patients.

1. Utilize interpreter services to facilitate client and provider communication as it relates to limited English proficient (LEP) clients.

2. Establish that the client requires evaluation as a close or high-risk contact to a pertussis case.

3. Ensure, to the extent possible, that the client seen for pertussis PEP clinical services is, in fact, who the person claims to be.

4. Ensure the client's consent, in the preferred language of the client, and signature have been obtained in accordance with agency policy and provide copies of the ***DSHS Privacy Notice*** and applicable signed consent forms.
   - ***DSHS General Consent and Disclosure*** (L-36), available at: www.dshs.state.tx.us/rls/pubs/GeneralConsentForm042010.pdf
   - ***DSHS Privacy Notice***, available at: http://www.dshs.state.tx.us/hipaa/privacynotices.shtm

5. Provide the ***Pertussis Information Sheet*** (ATTACHMENT 2) for the client to review. Explain the risks of pertussis. Provide the opportunity for the client to ask and receive satisfactory answers to any questions. If the client has questions the nurse cannot answer, contact the authorizing physician.

6. Evaluate the client, as outlined below, using the ***Pertussis PEP Eligibility Criteria Checklist*** (ATTACHMENT 3).
   a. Determine whether the client meets Section 1 eligibility criteria.
      i. If client does not meet Section 1 eligibility, **do not continue.** Place the ***Pertussis PEP Eligibility Criteria Checklist*** into the client's medical record. Go to Section E.11 of this SDO.
      ii. If client meets Section 1 eligibility, proceed to Section 2 of the checklist.

   b. Determine whether the client meets Section 2 eligibility criteria.
      i. If client does not meet Section 2 eligibility, **do not continue.** Place the ***Pertussis PEP Eligibility Criteria Checklist*** into the client's medical record. Go to Section E.11 of this SDO.
      ii. If client meets Section 2 eligibility, proceed to Section 3 of the checklist.

   c. Determine whether the client meets Section 3 eligibility criteria.
      i. If client does not meet Section 3 eligibility, **do not continue.** Place the ***Pertussis PEP Eligibility Criteria Checklist*** into the client's medical record. Go to Section E.11 of this SDO.
      ii. If client meets Section 3 eligibility, client is eligible to continue evaluation for pertussis PEP.

7. Perform a limited history and physical exam as described in Section F of this SDO and document on the ***Pertussis PEP Client Evaluation Form*** (ATTACHMENT 4).
8. Evaluate the client, as outlined below, using the ***Pertussis PEP Medication Contraindications and Precautions Checklist*** (ATTACHMENT 5).
   a. Determine whether the client has contraindications to azithromycin.
      i. If **no** contraindications to azithromycin are found, proceed to Section *Medications To Avoid When Used With Azithromycin* of the checklist.
      ii. If contraindications to azithromycin use are found, and the client is <2 months old, **do not continue.** Notify the authorizing physician for instructions.
      iii. If contraindications to azithromycin use are found, and the client is ≥2 months old, go to Section E.9.c of this SDO, *Contraindications To Use TMP-SMZ* Section of the ***Pertussis PEP Medication Contraindications and Precautions Checklist***.

   b. Determine whether the client is taking medications to **avoid** when used with azithromycin.
      i. If client is not taking any medications to avoid when using azithromycin, provide the ***Azithromycin for Pertussis PEP Fact Sheet*** (ATTACHMENT 6) for the client to review. Explain the benefits and risks of azithromycin. Provide the opportunity for the client to ask and receive satisfactory answers to any questions. If the client has questions the nurse cannot answer, contact the authorizing physician.
         - Have the client review and sign the *Pertussis PEP Client Attestation* Section of the ***Pertussis PEP Medication Contraindications and Precautions Checklist*** (ATTACHMENT 5).
         - If the client signs the *Client Attestation*, provide azithromycin to the client pursuant to the dosing guidelines (see Section E.13, **DOSING OF MEDICATIONS**, below) of this SDO.
         - Complete the *Azithromycin Medication Information Box of the* ***Pertussis PEP Medication Contraindications and Precautions Checklist.***
         - Go to Section E.10 of this SDO.
      ii. If client is taking medications to avoid when using azithromycin, contact the authorizing physician for instructions and document on the ***Pertussis PEP Medication Contraindications and Precautions Checklist.*** With direction from the authorizing physician, proceed to the *Contraindications To Use TMP-SMZ* section of the ***Pertussis PEP Medication Contraindications and Precautions Checklist***.

   c. If azithromycin is not provided and client is ≥2 months old, determine whether the client has contraindications to TMP-SMZ.
      i. If client does not have contraindications to TMP-SMZ, proceed to the *Medications To Avoid When Used With TMP-SMZ* Section of the ***Pertussis PEP Medication Contraindications and Precautions Checklist*** (ATTACHMENT 5).
      ii. If client has contraindications to TMP-SMZ, **do not continue.** Notify the authorizing physician for instructions and document on the ***Pertussis PEP Medication Contraindications and Precautions Checklist***.

   d. Determine whether the client is taking medications to avoid when used with TMP-SMZ.
      i. If client is not taking medications to avoid with TMP-SMZ, provide the ***TMP-SMZ for Pertussis PEP Fact Sheet*** (ATTACHMENT 7) for the client to review. Explain the benefits and risks of

TMP-SMZ. Provide the opportunity for the client to ask and receive satisfactory answers to any questions. If the client has questions the nurse cannot answer, contact the authorizing physician.

Have the client review and sign the *Pertussis PEP Client Attestation* Section of the ***Pertussis PEP Medication Contraindications and Precautions Checklist*** (ATTACHMENT 5).

If the client signs the Client Attestation, provide TMP-SMZ to the client pursuant to the dosing guidelines (see Section E.13, DOSING OF MEDICATIONS, below) of this SDO.

Complete the *TMP-SMZ Medication Information Box of the* ***Pertussis PEP Medication Contraindications and Precautions Checklist***.

ii. If client is taking medications to avoid with TMP-SMZ, **do not continue.** Contact the authorizing physician for instructions and document on the ***Pertussis PEP Medication Contraindications and Precautions Checklist***.

9. Complete the *Final Disposition* Section of the ***Pertussis PEP Eligibility Criteria Checklist*** (ATTACHMENT 5). Fax checklist to the DSHS Emerging and Acute Infectious Disease Branch at 512-776-7103 and to the Lead Epidemiologist for the Health Service Region of the patient. Place the completed form into the client's medical record.

10. Ask the client about his or her pertussis vaccination history and document on the ***Pertussis PEP Client Evaluation Form*** (ATTACHMENT 4). If the client's pertussis vaccination status is not current, determine if the client meets current DSHS Immunization Program eligibility criteria.
    - If client meets eligibility requirements, pertussis immunization may be provided as authorized in the Immunization SDO.
    - If client does not meet eligibility requirements, refer client to an appropriate immunization provider for pertussis vaccination.

11. Complete the ***Pertussis PEP Client Evaluation Form*** (ATTACHMENT 4) and place into the client's medical record.

12. **DOSING OF MEDICATIONS:**
    a. Consult the table below for the proper dosage of the antibiotic to be provided, if indicated.
    b. Infants and children must be weighed in order to calculate the proper dose of oral suspension. To convert weight in pounds to weight in kilograms divide weight in pounds by 2.2 (1kg = 2.2 lbs).

Recommended Antibiotic Dosing, By Age Group

Age Group	Azithromycin	TMP-SMZ
< 2 month	10mg/kg per day in a single dose for 5 days *	**TMP-SMZ is contraindicated for age < 2 months– do not provide TMP-SMZ to infants < 2 months.**
≥ 2-5 months	10mg/kg per day in a single dose for 5 days *	For infants aged ≥2 months – 5 months, TMP 8mg/kg per day, SMZ 40mg/kg per day in 2 divided doses for 14 days. Contact Pharmacy Branch at 512-776-7500 for product availability.

Infants (aged ≥6 months) and children	10mg/kg in a single dose on day 1, then 5mg/kg per day (maximum: 500mg) on days 2-5 * (<75 lbs use child dosing)	TMP 8mg/kg per day, SMZ 40mg/kg per day in 2 divided doses for 14 days. Contact Pharmacy Branch at 512-776-7500 for product availability. (<88 lbs use child dosing)
Adolescents and Adults	500mg in a single dose on day 1, then 250mg per day on days 2-5 "Z-Pak"(>75 lbs use adult dosing)	TMP 160mg, SMZ 800mg (one DS tablet) twice daily (12 hours apart) for 14 days (> 88 lbs use adult dosing)

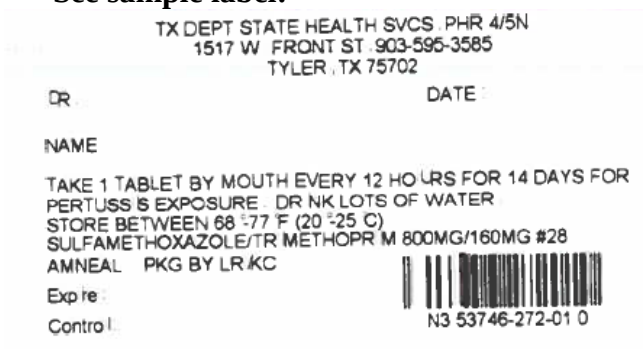
*Refer to **ATTACHMENT 8:** ***Pediatric Dosage Guidelines For Azithromycin Oral Suspension*** for specific instructions regarding *azithromycin oral suspension*.

c. If the DSHS regional pharmacy does not have the appropriate antibiotic available, order the antibiotic through the DSHS Pharmacy Branch. Antibiotics and supplies purchased by other programs (such as HIV/STD/TB) may not be used for pertussis PEP. Antibiotic should be given within a 21-day window of exposure.

d. As required by the Texas State Board of Pharmacy (Rule Title 22, Texas Administrative Code §291.93), the following information (in the client's preferred language) will be pre-printed on the medication label for self-administered medications:
   - The name, address, and telephone number of the clinic
   - The name and strength of the drug - if generic name, the name of the manufacturer or distributor of the drug
   - Quantity
   - Lot number and expiration date

   Complete the labeling directions so that it contains the following information:
   - The client's name
   - Date medication is provided
   - The authorizing physician's name
   - Directions for use (per Texas State Board of Pharmacy rules, incomplete directions for use may be present and if so, are to be completed by the authorized licensed nurse at time of provision)

See sample label:



e. Counsel the client regarding possible side-effects, conditions under which medications should be stopped and the clinic contacted, and the need to prevent pregnancy, if applicable.

G. Client Record-Keeping Requirements

Authorized licensed nurses must accurately and completely report and document each client visit on the ***Pertussis PEP Client Evaluation Form*** (ATTACHMENT 4) in a medical record prepared in accordance with DSHS policy and regional procedures, which will include:

1. Name of personnel involved in the evaluation and treatment at each visit, including the name of the interpreter (if an interpreter is used).
2. The client's personal health history (including pertussis vaccination history), the client's status including signs and symptoms, and physical examination findings.
3. Actions carried out under these standing orders.
4. Any additional physician orders.
5. Medications administered, prescribed, or provided to the client.
6. Client response(s), if any.
7. Contacts with other healthcare team members concerning significant events regarding client's status.
8. Documentation that the appropriate forms are completed and included in the medical record, and copies, when applicable, are provided to the client.

H. Scope of Supervision Required

This SDO gives the authorized licensed nurse authority to perform the acts described in this SDO under general supervision of the authorizing physician, in consultation with the authorizing physician as described in Sections F and I of this document.

I. Specialized Circumstances to Immediately Communicate with the Authorizing Physician

Specific circumstances that the licensed nurse providing services under this SDO should immediately contact the authorizing physician, but are not limited to:

1. A client is < 2 months old and has a contraindication to azithromycin.
2. A client is taking a medication that should be avoided when used with azithromycin and/or TMP-SMZ.
3. A client has a contraindication to TMP-SMZ.
4. A client is taking a medication that interacts with azithromycin and/or TMP-SMZ but is not listed in any of the "contraindications to use" or "medications to avoid" sections of the ***Pertussis PEP Medications Contraindications and Precautions Checklist.***
5. Other circumstances where medical direction or consultation is needed.

In an emergency, the authorized licensed nurse is to call 911, provide services as authorized in the regional emergency SDO, and contact his/her supervisor and/or the authorizing physician.

J. Limitations on Setting

The authorized licensed nurses can provide services under this standing order in the clinic setting, in the client's home, or in other field settings in which an authorizing physician can be contacted.

K. Date and Signature of the Authorizing Physician

It is the intent of all parties that the acts performed under this SDO shall be in compliance with the Texas Medical Practice Act, the Texas Nursing Practice Act, the Texas Pharmacy Act, and the rules promulgated under those Acts.

This SDO shall become effective on the date that it is signed by the authorizing physician, below, and will remain in effect until it is either rescinded, upon a change in the authorizing physician, or at the end of business on the last day of the current DSHS fiscal year (August 31, 2017), whichever is earlier.

Authorizing Physician's Signature:_____

Authorizing Physician's Title:_____

Printed Name: _____

Effective Date: _____

Emergency Contact Information (include cell phone number and the 24-hour number for the regional office):_____

Physician's DSHS email: _____

ATTACHMENT 1: *Attestation of Authorized Licensed Nurse*

I have read and understand the *DSHS Standing Delegation Orders: Immunization Clinical Services Provided by Registered Nurses and Licensed Vocational Nurses, FY2015-16 ("SDO")* that was signed by

Dr.____ on________________________________.
printed name of authorizing physician date of authorizing physician's signature

- I agree that I meet all qualifications for authorized licensed nurses outlined in the SDO.
- I agree to follow all instructions outlined in the SDO.

Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date

ATTACHMENT 1: *Attestation of Authorized Licensed Nurse (cont.)*

I have read and understand the *DSHS Standing Delegation Orders: Immunization Clinical Services Provided by Registered Nurses and Licensed Vocational Nurses, FY2015-16 ("SDO")* that was signed by

Dr._______________________________________ on______________________________.
printed name of authorizing physician — date of authorizing physician's signature

- I agree that I meet all qualifications for authorized licensed nurses outlined in the SDO.
- I agree to follow all instructions outlined in the SDO.

Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date
Printed name of authorized licensed nurse	Signature of Authorized Licensed Nurse	Date

ATTACHMENT 2: *Pertussis Information Sheet*

Pertussis Information Sheet

What causes pertussis?
Pertussis, also called whooping cough, is caused by a germ, *Bordetella pertussis.*

How does pertussis spread?
Pertussis is spread through the air by germs and is very easy to catch (contagious). If not treated, pertussis can spread easily to others.

How long does it take to show signs of pertussis after being near someone that has the germ?
It usually takes about 7 to 10 days after being near someone with pertussis to get sick. But, it could take just 4 days or up to 21 days for this to happen.

What are the symptoms of pertussis?
Pertussis usually starts like a common cold (runny nose, sneezing, low-grade fever, and a mild cough) but can worsen over 1–2 weeks.

People with pertussis may have coughing spells in which they can't catch their breath between coughs. As they catch their breath at the end of a coughing spell, they may loudly gasp, making a high-pitched "whoop"- hence the name, "whooping cough". They may also vomit or feel like they are choking. Young babies with pertussis may not have a "whoop" or even have a cough. Infants and young children often look very ill and seem to be suffering. The child may turn blue and vomit.

How serious is pertussis?
Pertussis can be a very bad disease, especially for infants. Infants 6 months of age and younger are the ones most likely to die from pertussis. The breathing problems that happen with this illness can be very upsetting and scary.

Adults are less likely than infants to become seriously ill with pertussis. Adults may go to the doctor a lot and miss work before pertussis is known to be the reason for the cough lasting so long. Adults with pertussis infection also can give the germ to infants they spend time with.

What are possible problems from pertussis?
Younger people have a greater chance of problems and going to the hospital for pertussis than older people.

Infants are also more likely to have a lung infection, seizures, or brain swelling. Other less serious complications include ear infection, poor appetite, and dehydration (not enough fluid). Adults with pertussis can have problems such as lung infection and broken ribs from coughing.

How do I know if my child or I have pertussis?
The doctor usually decides if someone has pertussis by learning the medical history and examining the patient. A lab test may be done by swabbing the back of the patient's throat (through the nose).

Is there a treatment for pertussis?
Antibiotics (a medicine that kills the germ) can prevent the spread of pertussis. The doctor wants people with pertussis to take antibiotics. Antibiotics are also recommended for some people that the health department decides have been close to someone with pertussis. People that have been close to someone with pertussis and are likely to become very sick with pertussis should get antibiotics. Other people who could give the germ to another person who could become very sick should also get antibiotics. Antibiotics can help prevent pertussis no matter what age you are or even if you have had a shot to prevent pertussis.

How long can a person with pertussis spread the germ?
People with pertussis are most able to spread the germ in the first two weeks after the cough starts. But, germs can be spread up to 21 days. Once the person starts taking antibiotics for pertussis, the person may still spread the germ for five more days. Anyone with pertussis that takes antibiotics should stay at home for at least 5 days after starting the medicine. Anyone with pertussis who does not take antibiotics should stay home for 21 days.

Can the spread of pertussis be stopped?
The spread of pertussis can be stopped by getting a pertussis shot, or vaccination. Pertussis vaccine comes together with vaccines for tetanus and diphtheria. This comes in one shot, called "DTaP" for kids. The DTaP is given at 2, 4, 6, and 15 months of age, and again when a child starts school. Doctors also advise that children get another dose of vaccine (called "Tdap") when the child is 11 to 12 years of age. In Texas, children must take these vaccines to go to school and daycare. If a child does not get all of the DTaP shots, the child should get them as soon as possible.

Adults who have not had an extra Tdap shot should get one. It is especially important that adults that are around infants get the Tdap shot. Pregnant women should get the Tdap shot during every pregnancy. It is best to get the vaccine when the woman is between 27 and 36 weeks pregnant. This helps to protect the new baby from getting pertussis.

Can you get pertussis more than once?
Pertussis vaccination is very important because it helps the body fight the pertussis germ. Getting pertussis again after being sick with pertussis does not happen often, but it does occur. The body may not be able to resist getting pertussis again.

ATTACHMENT 3: *Pertussis PEP Eligibility Criteria Checklist*

Client's Name: _____ Client's Date of Birth: _____

Client's County of Residence: _____

Case Name: _____Date of Assessment: _____

Name of Nurse and Jurisdiction Performing Assessment: _____

Section 1: Criteria Items for Confirmed Close or High Risk Contacts to a Pertussis Case:	**Yes**	**No**
Has the client been exposed to pertussis within the last 21 days?		
If box in Section 1 is checked Yes, continue to next section. If the answer is No, the client is not eligible for pertussis PEP. Do not continue to next section. Stop.		
Section 2: Criteria Items for Confirmed Close or High Risk Contacts to a Pertussis Case:	**Yes**	**No**
Is the client coughing?		
Does the client live in the same house as the case?		
If no, how many individuals live in the client's home? _____		
Is the client at high risk of severe illness?		
Will the client have close contact with someone at high risk of severe illness?		
High risk of severe illness includes: (check the applicable boxes)		
• Infant under 12 months		
If yes, name and date of birth of infant (if known):_____		
Woman in her third trimester of pregnancy		
• Person with preexisting health conditions that may be exacerbated by a pertussis infection (for example, immunocompromised persons or moderate to severe medically treated asthma)		
If at least one box in Section 2 is checked Yes, continue to next section. If all answers in Section 2 are No, the client is not eligible for pertussis PEP. Do not continue to next section. Stop.		
Section 3: Criteria Items for Confirmed Close or High Risk Contacts to a Pertussis Case:	**Yes**	**No**
Is the client unable to access medical care within a reasonable time period to prevent disease spread?		
Does the client lack financial resources to pay for medical care or PEP, based on the information provided by the client?		
Has the client's medical provider given guidance/recommendations for pertussis PEP that vary from DSHS and CDC recommendations?		
If at least one box in Section 3 is checked Yes, *complete next section at end of client visit.* If all answers in Section 3 are No, the client is not eligible for pertussis PEP *from DSHS*. Do not continue to next section. Stop.		

Final Disposition: Pertussis PEP provided ☐ **Azithromycin Tablets** ☐ **TMP-SMZ Tablets** ☐ **none**

☐ **Azithromycin Suspension (# of bottles____)** ☐ **TMP-SMZ Suspension**

Fax this form to the DSHS Emerging and Acute Infectious Disease Branch at (512) 776-7103.

Signature of Nurse Performing Assessment: _____

Texas Department of State Health Services Immunization Branch

Stock No. F11-14177. Rev.

ATTACHMENT 4: Pertussis PEP Client Evaluation Form

Pertussis PEP Client Evaluation Form
(to be placed into medical record)

Client Name: _____ Date of Birth: _____

Client Address: _____

City: _____ State: _____ Zip Code: _____

Pertussis Vaccination History: Date of Last Pertussis Vaccination: _____ Vaccination current? ☐ Yes ☐ No ☐ Unknown

If no or unknown, referred to ☐ DSHS ☐ other _____

Personal Health History:

☐ Personal Health History not completed as client not eligible for pertussis PEP from DSHS.

Medication Allergies: _____

Current Medications: _____

Chronic Health Conditions: _____

For females of childbearing potential, currently pregnant? ☐ Yes ☐ No

Current symptoms: ☐ Yes ☐ No If yes, list: _____

Limited Physical Exam:

☐ Limited Physical Exam not completed as client not eligible for pertussis PEP from DSHS.

Vital Signs: Weight (if a child): _____ Temperature: _____

General Inspection: ☐ Normal ☐ Abnormal If abnormal, describe: _____

Any other relevant signs of client's status: _____

Nursing Care Rendered and Actions Carried Out Under Standing Delegation Orders:

Check box to indicate the following forms are completed (and signed by client where indicated) and included in the medical record:

☐ *DSHS General Consent and Disclosure*

☐ *Pertussis PEP Medication Contraindications and Precautions Checklist* ☐ Not Applicable

☐ *Pertussis PEP Eligibility Criteria Checklist*

☐ If client eligible to continue evaluation for pertussis PEP, checklist faxed to DSHS Emerging and Acute Infectious Disease Branch at (512) 776-7103.

Check box to indicate the following forms have been provided to the client:

☐ *DSHS Privacy Notice*

☐ *Pertussis Information Sheet*

☐ *Azithromycin for Pertussis PEP Fact Sheet* ☐ Not Applicable

☐ *TMP-SMZ for Pertussis PEP Fact Sheet* ☐ Not Applicable

Pertussis PEP provided: ☐ azithromycin ☐ TMP-SMZ ☐ none ☐ did not meet eligibility criteria

Any Additional Physician Orders: _____

Continued on other side

Texas Department of State Health Services
Immunization Branch

Stock No. F11-14174
Rev. 03/2014

Client Responses, if any:_____

Contacts with other healthcare team members concerning significant events regarding client's status:_____

Description of other nursing care rendered:_____

Names of other personnel involved in evaluation and treatment, including interpreter, if applicable:_____

Nurse's Name:_____

Nurse's Signature:_____ Date:_____

Texas Department of State Health Services
Immunization Branch

Stock No. F11-14174
Rev. 03/2014

ATTACHMENT 5: *Pertussis PEP Medication Contraindications and Precautions Checklist*

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:** _____	☐	☐

Texas Department of State Health Services
Immunization Branch

TEXAS Department of State Health Services

Stock No. F11-14176
Rev. 06/2015

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:_____

AuthorizingPhysician:_____

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

Authorized Licensed Nurse Name:_____

Authorized Licensed Nurse Signature:_____

Texas Department of State Health Services
Immunization Branch

TEXAS Department of State Health Services

Stock No. F11-14176
Rev. 06/2015

ATTACHMENT 6: *Azithromycin for Pertussis PEP Fact Sheet*

Why is this medication prescribed?

Azithromycin is an antibiotic medicine used to treat certain bacterial (germ) infections, including pertussis ("whooping cough"). Azithromycin is recommended for postexposure antimicrobial prophylaxis (PEP) "prevention" after being in close contact to someone with pertussis. PEP can prevent death and serious health problems from pertussis in people at higher risk of getting very sick with pertussis. Azithromycin is in a group of medications called "macrolide antibiotics". It works by stopping the growth of bacteria.

How should this medicine be used?

Azithromycin comes as a tablet or liquid, taken once a day for 5 days. The medicine can be taken with or without food. To help you remember to take azithromycin, take it around the same time every day. Follow the directions on your prescription label carefully. Ask your doctor or nurse to explain any part you do not understand. Take azithromycin exactly as directed. Do not take more or less of the medicine. Do not take it more often than prescribed by your doctor.

Take azithromycin until you (or your child) have taken all the doses that the doctor prescribed, even if you feel better. If you stop taking azithromycin too soon or skip doses, your infection may not be completely treated. Then the antibiotics may not work on the bacteria.

Note: If using a liquid medicine for your child, there may be some medicine left in the bottle after taking all the doses prescribed by the doctor. Talk to your doctor or nurse if you have questions about how much medicine to take. Once your child has taken all the liquid medicine prescribed by your doctor, pour any left-over liquid medicine in the trash. Throw the empty medicine bottle in the trash, too.

What special precautions should I follow?

Before taking azithromycin, tell your doctor or nurse if you:

- Are allergic to azithromycin, clarithromycin (Biaxin, in Prevpac), dirithromycin (not available in the U.S.), erythromycin (E.E.S., E-Mycin, Erythrocin), telithromycin (Ketek), or any other medications.
- Or a family member have had any past heart beat conditions called QT prolongation, torsades de pointes, ventricular arrhythmias, or bradycardia.
- Have or ever had a recent myocardial infarction ("heart attack"), congestive heart failure, myasthenia gravis, recent colitis caused by antibiotics ("C diff"), liver problems or jaundice (yellowing of the skin or eyes), or kidney problems.
- Are taking or plan to take other prescription and nonprescription medications, vitamins, nutritional supplements, and herbal products. Be sure to mention any of the following:

  - BCG live intravesical
  - Dronedarone (Multaq), propafenone (Rythmol)
  - Pimozide (Orap)
  - Heart beat medications, such as amiodarone (Cordarone, Pacerone), disopyramide (Norpace), dofetilide (Tikosyn), ibutilide (Corvert), procainamide (Procanbid), quinidine, and sotalol (Betapace, Sorine)
  - Anticoagulants ("blood thinners") such as warfarin (Coumadin, Jantoven), enoxaparin (Lovenox), heparin
  - Carbamazepine (Tegretol)
  - Cyclosporine (Neoral, Sandimmune)
  - Digoxin (Lanoxin)
  - Phenytoin (Dilantin)
  - Ergot medicines for migraine such as dihydroergotamine (D.H.E. 45, Migranal), ergotamine (Ergomar, Cafergot, Bellargal)

If you are taking any of the medications listed, you may not be able to take azithromycin. **If you are taking two or more of the following medications, you may not be able to take azithromycin: phenothiazines, tricyclic antidepressants, ondansetron, fluoroquinolones, lithium, methadone.** Drugs other than those listed here may also interact with azithromycin. It is important to tell the doctor or nurse about all medicines you take.

What special instructions should I follow?
If you take antacids (Mylanta, Maalox, Rolaids, Milk of Magnesia, Pepcid Complete, or Tums), take them 2 hours before or 4 hours after taking azithromycin.

What should I do if I forget a dose?
Take the missed dose as soon as you remember it. However, if it is almost time for the next dose, skip the missed dose and take the next medicine dose at the regular time it is due to be taken. Do not take a double dose to make up for a missed one.

What side effects can this medication cause?
Azithromycin may cause side effects. Tell your doctor or nurse if any of these symptoms are severe or do not go away:

- nausea (queasy or upset stomach)
- diarrhea
- vomiting
- stomach pain
- heartburn
- headache

Some side effects can be serious. The following symptoms do not happen often, but if you have any of them, call your clinic immediately or get emergency medical treatment, such as calling "911":

- fast, pounding, or irregular heart beat
- dizziness
- fainting
- rash
- hives
- itching
- wheezing or difficulty breathing
- difficulty swallowing
- swelling of the face, throat, tongue, lips, eyes, hands, feet, ankles, or lower legs
- hoarseness
- mouth sores
- dark-colored urine
- severe diarrhea (watery or bloody stools) that may occur with or without fever and stomach cramps (may occur up to 2 months or more after your treatment)
- yellowing of the skin or eyes
- extreme tiredness
- unusual bleeding or bruising
- lack of energy
- loss of appetite
- pain in the upper right part of the stomach
- flu-like symptoms
- blisters or peeling of the skin
- unusual muscle weakness or difficulty with muscle control

Azithromycin may cause other side effects. Call your doctor or nurse if you have any unusual problems while taking this medicine.

What should I know about how to store this medicine?
Keep this medication in the container it came in, tightly closed, and out of reach of children. Store azithromycin at room temperature and away from high heat and moisture. Do not keep the medicine in the bathroom.

In case of emergency/overdose:
In case of overdose (too much medicine was taken), call your local poison control center at (800) 222-1222. If the person has collapsed or is not breathing, call local emergency services at 911.

What other information should I know?
Do not let anyone else take your medication. Your prescription is not able to be refilled. You will get the medicine you need in the first prescription.

It is important for you to keep a written list of all of the prescription and nonprescription (over-the-counter) medicines you are taking. Also list any products such as vitamins, minerals, or other dietary supplements. You should bring this list with you each time you visit a doctor or if you are admitted to a hospital. It is also important information to carry with you in case of emergencies.

Clinic information:

Name: _____

Address: _____

Phone Number: _____

Nurse: _____

Hoja informativa sobre la azitromicina para la profilaxis antimicrobiana postexposición (PEP) por pertussis

¿Por qué se receta esta medicina?
La azitromicina es un medicamento antibiótico que se usa para el tratamiento de ciertas infecciones bacterianas (por gérmenes), incluida la pertussis ("tosferina"). La azitromicina se recomienda como "prevención" para la profilaxis antimicrobiana postexposición (PEP) después de haber estado en contacto cercano con alguien con pertussis. La PEP puede prevenir la muerte y graves problemas de salud ocasionados por la pertussis en las personas que están en mayor riesgo de caer muy enfermas a causa de la pertussis. La azitromicina pertenece a un grupo de medicamentos denominados "antibióticos macrólidos". La manera en que trabaja es deteniendo el crecimiento de las bacterias.

¿Cómo se debe usar esta medicina?
La azitromicina tiene una presentación ya sea en tabletas o en líquido, y se toma una vez al día por 5 días. La medicina puede tomarse con o sin alimentos. Para ayudarle a recordar que debe tomar la azitromicina, tómela alrededor de la misma hora todos los días. Siga cuidadosamente las indicaciones en la etiqueta de su receta. Pídale a su doctor o a su enfermera que le explique cualquier parte que no entienda. Tome la azitromicina exactamente como le indicaron. No tome más ni menos medicina de la que se le recetó. No la tome con mayor frecuencia de la que su doctor le recetó.

Tome la azitromicina hasta que usted (o su hijo) hayan tomado todas las dosis recetadas por el doctor, incluso aunque se sienta mejor. Si usted deja de tomar la azitromicina demasiado pronto o deja de tomar una dosis, puede que su infección no haya sido completamente tratada. Y entonces los antibióticos podrían no actuar sobre la bacteria.

Nota: Si usted usa la presentación líquida de la medicina para su hijo, podría quedar cierta cantidad de la medicina en el envase después de haber tomado todas las dosis recetadas por el doctor. Pregunte a su doctor o enfermera si usted tiene dudas sobre cuánta medicina debe tomar. Una vez que su hijo se haya tomado toda la medicina líquida recetada por su doctor, tire la medicina líquida que haya sobrado a la basura. Tire también a la basura el envase vacío de la medicina.

¿Qué precauciones especiales debo tomar?
Antes de tomar azitromicina, dígale a su doctor o enfermera:

- Si usted es alérgico a la azitromicina, a la claritromicina (Biaxin, en Prevpac), a la diritromicina (no disponible en Estados Unidos), a la eritromicina (E.E.S., E-Mycin, Erythrocin), a la telitromicina (Ketek) o a cualquier otro medicamento.
- Si usted o algún familiar suyo han tenido en el pasado alguna de las siguientes afecciones de los latidos cardiacos: prolongación del QT, torsade de pointes, arritmia ventricular o bradicardia.
- Si usted tiene o ha tenido recientemente un infarto al miocardio ("ataque al corazón"), una insuficiencia cardiaca congestiva, miastenia gravis, una colitis reciente causada por antibióticos ("C. diff."), problemas del hígado o ictericia (coloración amarillenta de la piel o de los ojos) o problemas del riñón.
- Si usted está tomando o planea tomar otros medicamentos con o sin receta médica, vitaminas, suplementos nutricionales y productos a base de hierbas. Asegúrese de mencionar cualquiera de los siguientes:
  - Vacuna BCG de bacilo vivo por vía intravesical
  - Dronedarona (Multaq), propafenona (Rythmol) o Pimozida (Orap)
  - Medicamentos antiarrítmicos, como la amiodarona (Cordarone, Pacerone), disopiramida (Norpace), dofetilida (Ticosyn), ibutilida (Corvert), procainamida (Procanbid), quinidina y sotalol (Betapace, Sorine)
  - Anticoagulantes ("adelgazantes de la sangre") como la warfarina (Coumadin, Jantoven), enoxaparina (Lovenox), heparina
  - Carbamazepina (Tegretol)
  - Ciclosporina (Neoral, Sandimmune)
  - Digoxina (Lanoxin)
  - Fenitoína (Dilantin)
  - Medicinas derivadas del cornezuelo del centeno para tratar la migraña, como la dihidroergotamina (D.H.E. 45, Migranal), ergotamina (Ergomar, Cafergot, Bellargal)

Si usted está tomando alguno de los medicamentos antes enumerados, es probable que no pueda tomar azitromicina. Si usted está tomando dos o más de los siguientes medicamentos, es probable que no pueda tomar azitromicina: fenotiazinas, antidepresivos tricíclicos, ondansetrón, fluoroquinolonas, litio, metadona. Otros medicamentos distintos a los mencionados aquí podrían también interactuar con la azitromicina. Es importante que usted le diga a su doctor o enfermera cuáles son todas las medicinas que está tomando.

¿Qué indicaciones especiales debo seguir?

Si usted toma antiácidos (Mylanta, Maalox, Rolaids, Milk of Magnesia, Pepcid Complete o Tums), tómelos 2 horas antes o 4 horas después de tomar la azitromicina.

¿Qué debo hacer si olvido tomar una dosis?
Tome la dosis que olvidó tomar tan pronto lo recuerde. Sin embargo, si ya casi es hora de su próxima dosis, sáltese la dosis olvidada y tome la siguiente dosis de la medicina a la hora normal en que le corresponde tomarla. No tome una dosis doble para compensar la que olvid

¿Qué efectos secundarios puede causar esta medicina?
La azitromicina podría causar efectos secundarios. Dígale a su doctor o enfermera si alguno de los siguientes síntomas es grave o no desaparece:

- náusea (se siente indispuesto o con malestar estomacal)
- diarrea
- vómito
- dolor estomacal
- acidez
- dolor de cabeza

Algunos efectos secundarios podrían ser graves. Los siguientes síntomas no se presentan a menudo, pero si usted tiene alguno de ellos, llame a su clínica inmediatamente o busque tratamiento médico de emergencia, por ejemplo llamando al "911":

- latidos del corazón rápidos, fuertes o irregulares
- mareo
- desmayo
- sarpullido
- urticaria
- picazón
- sibilancia o dificultad para respirar
- dificultad para tragar
- hinchazón de la cara, la garganta, la lengua, los labios, los ojos, las manos, los pies, los tobillos o la parte inferior de las piernas
- ronquera
- úlceras en la boca
- orina de color oscuro
- diarrea grave (heces líquidas o con sangre) que podría ocurrir con o sin fiebre y retortijones de estómago (podría presentarse a los 2 meses o más después del tratamiento)
- coloración amarillenta de la piel o los ojos
- cansancio extremo
- hemorragias o moretones inusuales
- falta de energía
- pérdida del apetito
- dolor en la parte superior derecha del estómago
- síntomas parecidos a los de la gripe
- ampollas o descamación de la piel
- debilidad muscular inusual o dificultad para controlar los músculos

La azitromicina podría causar otros efectos secundarios. Llame a su doctor o enfermera si usted tiene algún problema inusual mientras esté tomando esta medicina.

¿Qué debo saber sobre cómo almacenar esta medicina?
Mantenga esta medicina en el envase en el que venía, firmemente cerrado, y fuera del alcance de los niños. Guarde la azitromicina a temperatura ambiente y lejos del calor y la humedad excesivos. No guarde la medicina en el cuarto de baño.

En caso de emergencia o de sobredosis:
En caso de sobredosis (cuando se ha tomado demasiada medicina), llame al centro de control de envenenamientos local al (800) 222-1222. Si la persona ha sufrido un colapso o no está respirando, llame a los servicios locales de emergencia al 911.

¿Qué otra información debo saber?
No deje que nadie más tome su medicina. Su receta no puede volver a surtirse. Usted recibirá la cantidad necesaria de medicina en la primera receta.

Es muy importante que usted mantenga una lista por escrito de todas las medicinas, tanto las recetadas como las de venta sin receta, que usted está tomando. Incluya además en la lista todos los productos como vitaminas, minerales u otros suplementos dietéticos que esté tomando. Lleve esta lista con usted cada vez que visite al doctor o si usted es ingresado en un hospital. Es importante también llevar esta información con usted en caso emergencias.

Información clínica:

Nombre: _____

Domicilio: _____

Número telefónico: _____

Enfermera: _____

ATTACHMENT 7: *TMP-SMZ (Bactrim, Septra, SMX/TMP) for Pertussis PEP Fact Sheet*

TMP-SMZ (Bactrim, Septra, SMX/TMP) for Pertussis PEP Fact Sheet

Why is this medication prescribed?
Sulfamethoxazole/Trimethoprim (Bactrim, Septra, SMX/TMP), called "TMP-SMZ", is an antibiotic medicine used to treat certain bacterial (germ) infections, including pertussis ("whooping cough"). TMP-SMZ is recommended for postexposure antimicrobial prophylaxis (PEP) "prevention" after being in close contact to someone with pertussis. PEP can prevent death and serious health problems from pertussis in people at higher risk of getting very sick with pertussis. TMP-SMZ is in a group of medications called "sulfa antibiotics". It works by slowing the growth of bacteria.

How should this medicine be used?
TMP-SMZ comes as a tablet or liquid, taken two times a day. **The medicine is usually taken with food and a full glass of water each time.** To help you remember to take TMP-SMZ, try to take it at the same times each day. Take the two doses 12 hours apart (example, take a dose at 7 in the morning, and another dose at 7 in the evening). Follow the directions on your prescription label carefully. Ask your doctor or nurse to explain any part you do not understand. Take TMP-SMZ exactly as directed. Do not take more or less of the medicine. Do not take it more often than prescribed by your doctor.

Take TMP-SMZ until you (or your child) have taken all of the doses that the doctor prescribed, even if you feel better. If you stop taking TMP-SMZ too soon or skip doses, your infection may not be completely treated. Then the antibiotics may not work on the bacteria.

What special precautions should I follow?
Before taking TMP-SMZ, tell your doctor or nurse if you:

- Are allergic to TMP-SMZ, Bactrim, Septra, trimethoprim, sulfamethoxazole, hydrochlorothiazide (HCTZ), sulfonylureas, any sulfa drug, or sulfonamides.
- Have or have ever had liver or kidney disease, hyperkalemia ("high potassium"), porphyria, lupus erythematosus ("lupus"), asthma, chronic alcohol use, recent colitis caused by antibiotics ("C diff"), or glucose-6-phosphate dehydrogenase (G-6-PD) deficiency.
- Are female and pregnant, trying to become pregnant, or breast-feeding.
- Are taking or plan to take any other prescription and nonprescription medications, vitamins, nutritional supplements, and herbal products. Be sure to mention any of the following:
  - BCG live intravesical
  - Methenamine (Urex, Hiprex)
  - Anticoagulants ("blood thinners") such as warfarin (Coumadin, Jantoven), enoxaparin (Lovenox), heparin
  - Methotrexate
  - Oral diabetes medicines such as sulfonylureas (Glipizide, Glimepiride), thioglitazones (Actos, Avandia)
  - Dofetilide (Tikosyn)
  - Digoxin (Lanoxin)
  - Leucovorin
  - Amiodarone (Cordarone, Pacerone)
  - Phenytoin (Dilantin)
  - Pyrimethamine (Daraprim)
  - Thiazide diuretics (HCTZ)
  - Topical retin A, tretinoin
  - Medications that can increase serum potassium levels such as ACE inhibitors, angiotensin receptor blockers, potassium-sparing diuretics, potassium supplements, and spironolactone

If you are taking any of the medications listed, you may not be able to take TMP-SMZ. Drugs other than those listed here may also interact with TMP-SMZ. It is important to tell the doctor or nurse about all medicines you take.

What special instructions should I follow?
TMP-SMZ may cause an upset stomach. **Take TMP-SMZ with food and a full glass of water each time.**

Texas Department of State Health Services
Immunization Branch

TEXAS Department of State Health Services

Stock No. 11-14178
Rev. 06/2015

Avoid unnecessary or prolonged exposure to sunlight and wear protective clothing, sunglasses, and sunscreen.
TMP-SMZ may make your skin burn more easily in the sunlight.

What should I do if I forget a dose?
Take the missed dose as soon as you remember it. However, if it is almost time for the next dose, skip the missed dose, and take the next medicine dose at the regular time it is due to be taken. Do not take a double dose to make up for a missed one.

What side effects can this medication cause?
TMP-SMZ may cause side effects. Tell your doctor or nurse if any of these symptoms are severe or do not go away:

- nausea (queasy or upset stomach)
- vomiting
- loss of appetite

Some side effects can be serious. The following symptoms do not happen often, but if you have any of them, call your clinic immediately or get emergency medical treatment, such as calling "911":

- skin rash
- sore throat
- mouth sores
- yellowing of the skin or eyes
- joint aches
- itching
- fever or chills
- unusual bruising or bleeding
- paleness

TMP-SMZ may cause other side effects. Call your doctor or nurse if you have any unusual problems while taking this medicine.

What should I know about how to store this medicine?
Keep this medication in the container it came in, tightly closed, and out of reach of children. Store TMP-SMZ at room temperature and away from high heat and moisture. Do not keep the medicine in the bathroom.

In case of emergency/overdose:
In case of overdose (too much medicine was taken), call your local poison control center at (800) 222-1222. If the person has collapsed or is not breathing, call local emergency services at 911.

What other information should I know?
Do not let anyone else take your medication. Your prescription is not able to be refilled. You will get the medicine you need in the first prescription.

It is important for you to keep a written list of all of the prescription and nonprescription (over-the-counter) medicines you are taking. Also list any products such as vitamins, minerals, or other dietary supplements. You should bring this list with you each time you visit a doctor or if you are admitted to a hospital. It is also important information to carry with you in case of emergencies.

Clinic information:

Name:_____

Address:_____

Phone Number:_____

Nurse:_____

ATTACHMENT 8: ***Pediatric Dosage Guidelines For Azithromycin Oral Suspension***

1. Available formulations are supplied to provide two different drug concentrations/strengths (100 mg/5 mL, or 200 mg/5 mL), and to provide three different bottle sizes (15 mL, 22.5 mL and 30 mL volumes).
2. Azithromycin oral suspension contains a flavored suspension that requires reconstitution (mixing) with water before use.
3. Before reconstituting azithromycin oral suspension, the authorized license nurse consults the ***Pediatric Dosage Guidelines For Azithromycin Oral Suspension, Based on Age and Body Weight*** tables below for the proper strength and size of bottle(s).

Pediatric Dosage Guidelines For Azithromycin Oral Suspension,
Based on Age and Body Weight
Concentration Strength: 100 mg/5mL
Age <6 months
Dosing Calculated as 10 mg/kg in a single dose for 5 days

Weight (in KG)	100 mg / 5 mL **Day 1-5**	Total mL / Treatment Course	Total mg/ Treatment Course	# Bottle(s) Required per Client
0 - 7.5	2.5 mL (1/2 tsp)	12.5 mL	250 mg	1 Bottle of 100mg/5ml
7.6-12.5	5 mL (1 tsp)	25 mL	500 mg	2 Bottles of 100mg/5ml

Concentration Strength: 100 mg/5mL
Age ≥6 months
Dosing Calculated as 10 mg/kg in a single dose on Day 1, then 5 mg/kg per day on Days 2-5

Weight (in KG)	100 mg / 5 mL **Day 1**	100 mg / 5 mL **Days 2-5**	Total mL / Treatment Course	Total mg/ Treatment Course	# Bottle(s) Required per Client
0 - 7.5	2.5 mL (1/2 tsp)	1.25 mL (1/4 tsp)	7.5 mL	150 mg	1 Bottle of 100mg/5ml
7.6-12.5	5 mL (1 tsp)	2.5 mL (1/2 tsp)	15 mL	300 mg	1 Bottle of 100mg/5ml

Note change in formulation concentration and different bottle sizes below!
ATTACHMENT 8: *Pediatric Dosage Guidelines*
For Azithromycin Oral Suspension, Continued

Concentration Strength: 200 mg/5mL
Age ≥6 months
Dosing Calculated as 10 mg/kg in a single dose on Day 1, then 5 mg/kg per day on Days 2-5

Weight (in KG)	200 mg / 5 mL **Day 1**	200 mg / 5 mL **Days 2-5**	Total mL / Treatment Course	Total mg/ Treatment Course	# Bottle (s) Required per Client
12.6-25.0	5 mL (1 tsp)	2.5 mL (½ tsp)	15 mL	600 mg	1 Bottle of 200mg/5ml: 15mL
25.1-35.0	7.5 mL (1 & ½ tsp)	3.75 mL	22.5 mL	900 mg	1 Bottle of 200mg/5ml: 22.5 mL
35.1-45.0	10 mL (2 tsp)	5 mL (1 tsp)	30 mL	1200 mg	1 Bottle of 200mg/5ml: 30 mL
≥45.1	12.5 mL (2 & ½ tsp)	6.25 mL (1 & ¼ tsp)	37.5 mL	1500 mg	1 Bottle of 200mg/5ml: 15mL **AND** 1 Bottle of 200mg/5ml: 22.5 mL

4. The table below indicates the volume of water to be added to the azithromycin bottle for reconstitution of azithromycin oral suspension. Shake well after adding the water and review these special instructions for azithromycin oral suspension (preprinted on the medication bottle) with the pediatric client's parent(s) or guardian(s):
   - "Shake well before each use."
   - "Keep tightly closed."
   - "After mixing, store suspension at ROOM TEMPERATURE and use within 10 days."
   - " Pour any remaining medication into the trash after all doses have been taken."

ATTACHMENT 8: ***Pediatric Dosage Guidelines For Azithromycin Oral Suspension, Continued***

Volume of Distilled Water to be Added to the Azithromycin Bottle

for Reconstitution of Azithromycin Oral Suspension

Strength: Azithromycin concentration after reconstitution	Size of bottle: Total volume after Reconstitution (azithromycin content)	Amount of distilled water to be added
100 mg/5 mL	15 mL (300 mg)	**9 mL**
200 mg/5 mL	**15 mL** (600 mg)	**9 mL**
200 mg/5 mL	**22.5 mL** (900 mg)	**12 mL**
200 mg/5 mL	**30 mL** (1200 mg)	**15 mL**