

BASIC SUBCUTANEOUS INSULIN ORDER SET

All orders with “☒” will be followed unless crossed out

Date: _____

Time: _____

1. DISCONTINUE PRIOR DIABETIC REGIMEN (list below):

- Discontinue: _____
- Discontinue Subcutaneous Insulin Sliding Scale if previously ordered

2. MONITOR BLOOD GLUCOSE:

- Before every meal and bedtime (2100) OR every 4 hours when NPO
- Lab – HgbA1C (unless already ordered this admission)
- 0200 blood glucose if glulisine (Apidra®) given at bedtime

3. LONG ACTING/BASAL INSULIN:

- Insulin glargine (Lantus®) _____ units subq at bedtime (2100 hours) **OR** q 24 hours at _____
 - Give full dose EVEN if NPO, on clear or full liquids or eating < 50% of their meal
- Insulin NPH _____ units subq before breakfast and _____ units subq at bedtime (2100)
 - Give 50% of the dose if NPO, on clear or full liquids or eating < 50% of their meal

Physician choose **ONLY one**
See reverse for dosing guide

4. RAPID ACTING/BOLUS INSULIN:

A. Scheduled Nutritional/Meal glulisine (Apidra®) Insulin Orders

- Administer within 30 minutes of the start of the meal.
- Hold if NPO, on clear or full liquids, or eating < 50% of the meal
- If blood sugar <70, follow hypoglycemia orders below, decrease scheduled Apidra dose by 50% and give at the completion of meal

Insulin Apidra _____ units subq with each meal

OR

Carbohydrate Counting Option: Insulin apidra 1 unit per _____ grams of carbohydrate (CHO) subq immediately after each meal. (1 CHO exchange = 15 grams)

B. Supplemental insulin glulisine (Apidra®) orders: Administer along with scheduled meal

Apidra insulin orders in 4A

- Continue to give if NPO but use the scale for BMI <25
- Always use the “Bedtime” scale for the bedtime and 0200 BG in patients who are eating
- Use the other scale checked by the physician for all other blood glucose values

By scale below (In general, exclusive use of this scale is discouraged.)

OR

(Blood sugar - 120)/correction factor _____ = number of supplemental units

5. HYPOGLYCEMIA ORDERS for BG <70 mg/dL: Notify physician as soon as possible.

- If conscious and able to swallow: 5 gram glucose tabs are the preferred treatment for patients that are eating.
 - For BG 50-69 mg/dl, give 15 grams oral carbohydrate
 - For BG < 50 mg/dl, give 30 grams oral carbohydrate
 - Repeat blood glucose check and treatment q 15 minutes until ≥70mg/dL
- If semi-conscious, unconscious, uncooperative, unable to swallow or is NPO:
 - Administer 50 ml of D₅₀W slow IV push
 - OR** if no IV access then Glucagon 1mg SubQ or IM and establish an IV
 - Repeat glucose check and treatment q 10 minutes until ≥70mg/dL
- Once ≥70mg/dL, repeat blood glucose check q 1 hour X 3 to monitor for recurrence.

Physician choose **ONLY one**
See reverse for dosing guide

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Glucose	Supplemental glulisine (Apidra®) scale: Use scale with daytime and q 4 hour blood glucoses					☒ Bedtime Scale (2100 and 0200) – for ALL eating patients
	<input type="checkbox"/> BMI <25, non-diabetic, NPO or on Dialysis	<input type="checkbox"/> BMI 25-30	<input type="checkbox"/> BMI > 30	<input type="checkbox"/> OTHER	<input type="checkbox"/> Post OP CV Surgery	
<70	Follow Hypoglycemia Orders (Above) AND Reduce Scheduled Dose of Apidra by 50%					
70-110 mg/dl	No change	No change	No change		No Change	No rapid insulin
111-130 mg/dl	No change	No change	No change		+1 units Apidra	No rapid insulin
131-150 mg/dl	No change	No change	No change		+2 units Apidra	No rapid insulin
151-175 mg/dl	+1 units Apidra	+2 units Apidra	+3 units Apidra		+3 units Apidra	No rapid insulin
176-200 mg/dl	+2 units Apidra	+3 units Apidra	+4 units Apidra		+4 units Apidra	1 units Apidra
201-225 mg/dl	+3 units Apidra	+4 units Apidra	+5 units Apidra		+5 units Apidra	2 units Apidra
226-250 mg/dl	+4 units Apidra	+5 units Apidra	+6 units Apidra		+6 units Apidra	3 units Apidra
251-300 mg/dl	+6 units Apidra	+7 units Apidra	+8 units Apidra		+8 units Apidra	4 units Apidra
301-350 mg/dl	+8 units Apidra	+9 units Apidra	+10 units Apidra		+10 units Apidra	5 units Apidra
351-400 mg/dl	+10 units Apidra	+11 units Apidra	+12 units Apidra		+12 units Apidra	6 units Apidra
≥401 mg/dl	+12 units Apidra	+13 units Apidra	+14 units Apidra		+14 units Apidra	7 units Apidra

Physician Signature: _____

Pager # _____

BANNER INPATIENT BASAL INSULIN GUIDE

(See Banner Intranet Dosing Tool: Home page → "Departments" → "Pharmacy" → "insulin dosing tool" Excel file)

<p>Step 1: -Discontinue oral antidiabetic agents if using this protocol.</p> <p>-For the ICU, insulin gtt is the regimen of choice except during brief stays or in preparation of transfer to the floor.</p> <p>-Check HbA1C and if it is >8 then consider making a change to their home regimen at the time of discharge. The hospital is not the ideal place to titrate oral medications since activity and intake vary.</p> <p>-Targets:</p> <ul style="list-style-type: none"> • For most patients on the medical/surgical floors, fasting blood sugars of 70-140 mg/dL and less than 180 mg/dl at all times • Patients with hypoglycemic risk factors (renal failure, end stage liver disease, hyperbaric therapy, tapering steroid doses, etc), then goal fasting glucose values should be 90-150 mg/dl. • Post op cardio-thoracic surgery goals are 80-110 mg/dL fasting and less than 150-180 at all times. 	<p>Step 2: Calculate the estimated total daily dose (TDD) of insulin based on ONE of the following methods (in order of preference)</p> <ol style="list-style-type: none"> 1. Transferring from insulin gtt. Use average hourly rate over the last 6 hours (exclude any increased rates that covered a meal), multiply by 20 to get the TDD 2. Use total insulin required at home (all types added together) 3. Calculate/ estimate insulin requirement as follows based on body size: <ol style="list-style-type: none"> a. Dialysis (regardless of BMI) or CrCl<15 mL/min use 0.3 units/kg/day, b. Lean (BMI < 25), CrCl 15-30 mL/min new steroid induced hyperglycemia or new diagnosis of DM: use 0.4 units/kg/day c. Overweight (BMI 25-30) use 0.5 units/kg/day, d. Obese (BMI > 30) use 0.6 units/kg/day <p style="text-align: center;">TOTAL DAILY DOSE (TDD) of insulin = _____ Units</p>	<p>Step 3: Determine the distribution of the TDD: Note: if basal insulin exceeds 50% of the TDD the patient is at higher risk for hypoglycemia for longer periods of time if the nutrition source is stopped. IF the patient is on high dose steroids, consider giving only 30% of TDD as basal and 70% meal.</p>
<p>Long Acting/Basal: Glargine (Lantus®) OR NPH</p> <p>Lantus – 50% of TDD given once daily at HS or q 24 hours at the time of the first dose</p> <p>NPH - 50% of TDD divided into 2/3 in the am and 1/3 at bedtime IF on continuous tube feeds then give</p> <p>For the first day,</p> <ul style="list-style-type: none"> • If it is prior to noon, consider giving ½ the usual bedtime dose of glargine once only now OR giving a dose of NPH OR glargine q 24 h with the first dose now • If you are stopping an insulin drip, give glargine or NPH 2-4 h prior to turning drip off then q 24 h with the first dose now 	<p>Rapid acting/Bolus: glulisine (Apidra®)</p> <p>Meal/Nutritional Coverage</p> <ol style="list-style-type: none"> 1. Meals or 3 bolus tube feeds daily: <ol style="list-style-type: none"> a. 50% of TDD as glulisine (Apidra®) in three equal doses prior to each meal b. OR Use the carbohydrate exchange calculation if they are on it at home or have particularly irregular eating. Typical starting dose: 1 unit per 15 grams of carbohydrate (one exchange). 2. Continuous tube feeds: 50% of TDD as glulisine (Apidra®) in six equal doses prior to each meal <p>Supplemental: Given in addition to the routine pre-meal dose or when NPO based on results of fingerstick testing.</p>	<p>Step 4: EVALUATE insulin dose daily. Determine the total dose received for the day prior and adjust as below (calculations also available on the Banner intranet insulin dosing tool) to attain the targets listed in Step 1</p> <ol style="list-style-type: none"> a. If some glucoses were < 80 mg/dl use 80% of yesterday's total insulin given as new total b. If some glucoses were > 180 mg/dl and none < 80 mg/dl use 110 % of yesterday's total as new total c. Redistribute your new total into 50% basal and 50% bolus d. If the supplemental scale is not matching your patient's needs, consider calculating the expected decrease in glucose for one unit of insulin (correction factor) by using 1700/ TDD given = Correction factor