<table>
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<th>Medication</th>
<th>Precautions</th>
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| Cisplatin        | • A computer system is utilized with the following:  
|                  |   • Dose warnings  
|                  |   • Label generation  
|                  |   • The order is reviewed by an Oncology pharmacist before it is entered into the computer  
|                  |   • Safe handling recommendations are utilized  
|                  |   • Similar agents are not stored together  
|                  |   • Generic names are verified when prescribed by chemical name or abbreviation  
|                  |   • A protocol based system which calculates drug/dose based on patient specific parameters is utilized  
|                  |   • The drug is always prepared by an Oncology Pharmacy Technician or Pharmacist  
| Carboplatin      |                                                                                                                                                                                                             |
| Concentrated     | • Concentrated oral morphine solutions are only dispensed when ordered for a specific patient (not as unit stock)  
| liquid morphine  | • Concentrated solutions are purchased and dispensed in dropper bottles  
| products         | • The Patient and caregiver’s understanding of how to measure the proper dose for self-administration at home is verified. (Home Health)  
| Conventional     | • Similar agents are not stored together  
| liquid morphine  | • Safe handling recommendations are utilized  
| concentrations   | • The drug is always prepared by a trained Oncology Pharmacy Technician or Pharmacist  
| Fentanyl         | • Sufentanil is not stocked in patient care units outside of L&D, OR and PACU  
| Sufentanil       | • These agents are not stocked together or near one another if both products are available  
| Hydromorphone    | • For inpatient units, specific strengths are stocked for each product that is dissimilar. Stock of hydromorphone will be 2-mg unit dose cartridges, and morphine is 4-mg or higher unit dose cartridges.  
| injection        | • Health care providers are educated and reminded that these two products are not interchangeable  
| Lipid based      | • Pharmacy staff, involved in handling these products, is educated on the differences between conventional and lipid-based formulations of these drugs.  
| amphotericin     | • Staff are encouraged to refer to the lipid-based products by their brand names and not just their generic names  
| Conventional     | • Stop and verify that the correct drug is being used if staff, patients or family members notice a change in the solution’s appearance from previous infusions. Lipid-based products may be seen as cloudy rather than a clear solution  
| forms of         | • Lipid-based products are not stored in patient care areas  
| amphotericin     | • Ordering is restricted to ID physicians  
| Insulin Products:| • The variety of insulin products are limited and stored in patient care units  
| Lantus®          | • Patient-specific insulin vials are removed upon patient discharge  
| Lente®           | • In patient units, stock in red "high alert" containers  
| Humalog®         |                                                                                                                                                                                                             |
| Novolog®         |                                                                                                                                                                                                             |
| Humulin®         |                                                                                                                                                                                                             |
| Humalog®         |                                                                                                                                                                                                             |
| Novolin®         |                                                                                                                                                                                                             |
| Novolin 70/30®   |                                                                                                                                                                                                             |
| Novolog®         |                                                                                                                                                                                                             |
| Novolog Mix 70/30®|                                                                                                                                                                                                             |
| Look-Alike Sound-Alike Medication List                                                                                                                                                                   |

### General Recommendations:

- Awareness of look-alike and sound-alike drug names is reinforced by provision of information to the professional staff on regular basis
- Whenever possible, the purpose of the medication is determined before dispensing or drug administration
- Verbal or telephone orders:
  - are discouraged unless truly necessary
  - should never be accepted for chemotherapeutics
  - must be read-back per the required verbal order procedure
- The possibility of name confusion is always considered when adding a new product to the formulary. Information previously published by safety agencies is reviewed as well
- Products with look or sound-alike names are not stored next to each other in pharmacies, patient care units, and in other settings, including patient homes
- Reporting of errors and potentially hazardous conditions with look and sound-alike product names is encouraged by completing a UOR and the information is utilized to established priorities for error reduction
- Within the home setting, when clinical providers identify that the patient is taking any of the look-alike sound-alike medications in the home, any of the following precautionary actions may be taken:
  - Assist medications are clearly labeled
  - Instruct patient or their caregiver on the use of pill sorters
  - Color code medication containers
  - Place medications in different locations in the home (bathroom vs. kitchen)
  - Notify Provider/Pharmacy to check if other medication options are available
  - Provide safety precaution education related to medication use to prevent injury