ALCOHOL WITHDRAWAL PREVENTION/TREATMENT ORDERS
LORAZEPAM (ATIVAN)
PAGE 1 OF 2

Allergy/Sensitivities and Reactions:

- Consult Behavioral Health. ________________________________ Reason: ______________________________________________________
- Consult Addiction Medicine ________________________________ Reason: ______________________________________________________
- Consult Social Work for assessment and aftercare for alcohol use disorder. __________________________________________________

MEDICATIONS:

NUTRITIONAL SUPPORT
- Thiamine 100 mg in 50 ml Normal Saline IV piggyback times 1 dose. (Administer over 15-30 minutes.)
- Thiamine 100 mg orally daily on days two and three
- Folic Acid 1 mg orally once daily for three days
- Multivitamin 1 tablet/capsule orally daily for three days
- If patient NPO add Thiamine 100 mg, Folic Acid 1 mg, multivitamin 10 ml to first IV bag daily for three days.
- IV fluid ___________________________________________________ at _________ ml/hour.
- Magnesium Sulfate Replacement per policy *(For Adult ICU Patients only)*
- Magnesium Sulfate □ 1 gm □ 2 gm OR □ 4 gm IV piggyback times one over 6 hours.

Wernicke Korsakoff Syndrome Treatment
- Thiamine 200 mg in 50 ml Normal Saline IV piggyback times 1 dose. (Administer over 15-30 minutes.)

ANTI-PSYCHOTIC/ANTI-AGITATION MEASURES *(only as adjunctive therapy after adequate sedative use.)*
- Haloperidol (Haldol) 5mg orally or IM every 4 hours as needed *(maximum dose: 15 mg/day.)*
  *(for hallucinations, delusions, agitation not adequately controlled by Lorazepam)*
  *(Caution: may lower seizure threshold. QTc should be less than 450 msec.)*
- Other: ______________________________________________________________________________________________

ANTI-EMETICS: *(Phenothiazines may lower seizure threshold and are not recommended).*
- Ondansetron (Zofran) 4 mg orally every 6 hours as needed for nausea or vomiting
- Ondansetron (Zofran) 4 mg IV every 6 hours as needed for nausea or vomiting
- Other: ______________________________________________________________________________________________

ANTI-PYRETICS/ANALGESICS: *(Select one): Caution re: GI Bleeding with NSAID.*
- Acetaminophen (Tylenol) 325 mg orally every 4 hours as needed for temperature greater than 100° F or for pain.
  *(maximum dose 2gm/day for first 5 days.)* **Caution re: Hepatotoxicity.**
- Ibuprofen (Motrin) 400 mg orally every 6 hours as needed for temperature greater than 100° F or for pain.
- Other: ______________________________________________________________________________________________

Emergency Verbal Order or Telephone Order / Read back by: Date: Time: 
Transcriber’s Signature: Date: Time: 
Prescriber’s Printed Name: Noting Nurse’s Signature: Date: Time: 
Prescriber’s Signature: Complete Call Back Number ( ) ___ ___ ___ - ___ ___ ___ ___ Date: Time: 

Form faxed to pharmacy: Date/Time: By: ________________________ 
Alcohol Withdrawal Prevention/Treatment Lorazepam (Ativan) Orders Page 1 of 2
NURSING
- Do not use CIWA scale in mechanically ventilated patients.
- DO NOT USE flumazenil (Romazicon) under any circumstances.
- Call physician:
  - If total dose of Lorazepam (Ativan) dose exceeds 24 mg/24 hours.
  - If blood pressure less than 90/60 mmHg, respiratory rate less than or equal to 8; pulse oximetry less than or equal to 90%.
  - If patient continues to have significant alcohol withdrawal symptoms with increasing CIWA score while on the protocol.
  - Consider stopping protocol if CIWA score less than 4 for 24 hours after treatment stops.
  - Once stable for 24 hours, to consider longer-acting medication therapy or tapering over 72 hours.
- If CIWA score is 0-4 or patient is not receiving Lorazepam, repeat CIWA every 4 hours until stable for 72 hours.
- Document CIWA score, treatment and reassessment.
- Do NOT hold Lorazepam if patient is sleeping. Wake patient if sleeping to repeat CIWA.
- Include vital signs and pulse oximetry with each CIWA assessment.
- Seizure Precautions
- Fall Precautions
- Nursing to provide Alcohol Recovery patient education material and review with patient prior to discharge.
- Oral medication is preferred unless the patient is NPO, unable to swallow or quicker action is required.

**Symptom Triggered Therapy**
Select for patients with no history of alcohol withdrawal seizures or severe alcohol withdrawal.

<table>
<thead>
<tr>
<th>CIWA Score</th>
<th>Lorazepam/ (Ativan) dose</th>
<th>CIWA Re-Assessment, Dosing and Documentation Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Repeat CIWA one hour after each dose for Response*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Same or / Increasing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stable and / or Decreasing</td>
</tr>
<tr>
<td>5 - 9</td>
<td>1 mg PO / IV Push</td>
<td>every 4 hours</td>
</tr>
<tr>
<td>10 - 14</td>
<td>2 mg PO / IV Push</td>
<td>every 2 hours</td>
</tr>
<tr>
<td>15 - 19</td>
<td>3 mg PO / IV Push</td>
<td>every 1 hour</td>
</tr>
</tbody>
</table>

CIWA 20 or greater, call Rapid Response Team to evaluate and contact intensivists.

*Response
- If CIWA is 5 points HIGHER than prior score, immediately give next dose for current score then call physician for re-consideration of additional dosing.
- If CIWA is 5 points LOWER than the last score, repeat CIWA just before next scheduled dose and medicate according to score.
- Use falling CIWA schedule AFTER CIWA score stable or falling for at least three measurements taken JUST BEFORE scheduled dose of medication AND patient's general condition is improving during the same time frame.

**Add Fixed Dose Along With Above Symptom Triggered Therapy**
Select for patients with history of alcohol withdrawal seizures, severe alcohol withdrawal or benzodiazepine tolerance. Avoid added fixed dose therapy in elderly patients.
- Lorazepam (Ativan) 2 mg PO/IV Push every 6 hours times 8 doses
- Lorazepam (Ativan) 1 mg PO/IV Push every 6 hours times 8 doses
- Re-evaluate fixed dose after 48 hours

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Prescriber’s Printed Name:
Noting Nurse’s Signature:
Date: ____________________ Time: ____________________

Prescriber’s Signature:
Complete Call Back Number (________) ________ ________ - ________ ________ ________ ________
Date: ____________________ Time: ____________________

Form faxed to pharmacy: Date/Time: ____________________ By: ____________________
10-6000-256 REVISED 9/7/12
White - Chart Copy - Transmit to Pharmacy
Alcohol Withdrawal Prevention/Treatment
Lorazepam (Ativan) Orders Page 2 of 2