Targeted Look-alike / Sound-alike Medications

Drug Names	Potential Error and Consequences
CeleBREX Cerebyx CeleXA	Similarity in names can lead to confusion between these three products. Confusion between the pain medication (Celebrex), the anticonvulsant (Cerebyx), and the antidepressant (Celexa) could lead to serious adverse drug events.
clonazePAM cloNIDine cloZAPine cloBAZam	Similarity in names can lead to confusion between these four products. Confusion between the anxiolytic (Clonazepam), the hypertensive med (Clonidine), the antipsychotic med (Clozapine) and the anxiolytic/anticonvulsant med (Clobazam) could lead to serious adverse drug events.
CloNIDine KlonoPIN	The generic name for clonidine could easily be confused with the trade name Klonopin.
DOPamine DOBUTamine	Similarity in names can lead to confusion between these two products.
ePHEDrine EPINEPHrine	The names and packaging of these two medications look very similar creating potential for errors.
HYDROmorphone morphine	Hydromorphone is approximately seven to eight times_more potent than morphine. Fatal errors have occurred when hydromorphone was confused with morphine.
HydrOXYzine HydrALAZINE	Similar names have resulted in medication errors. Confusion between the antihistamine (hydroxyzine) and the antihypertensive agent (hydralazine) could lead to serious adverse drug events.
INSULIN: • Lantus (glargine) • HumaLOG (lispro) • NovoLOG (aspart) • Regular (HumuLIN/NovoLIN) • Regular Concentrated (U-500) • 70/30 (HumuLIN/NovoLIN) • HumaLOG Mix 75/25 • NovoLOG Mix 70/30 • NovoLOG Mix 50/50 • Levemir (determir)	 Inappropriate insulin given due to "Look-Alike/Sound-Alike" errors (e.g. Humalog/Humulin) Confusion of dose (units vs. ml) Drip rate errors Incorrect correction scale interpretations Inaccurate computer order entry leading to dosing errors Insulin errors have the potential to cause severe hypo/hyperglycemia. These effects may require extra monitoring, require treatment, or in severe cases may be fatal.
LamISIL LaMICtal	Similar names have resulted in medication errors. Confusion between the antifungal (Lamisil) and the anticonvulsant (Lamictal) could lead to serious adverse drug events.
levoFLOXacin levETIRAcetram	Similarity in names can lead to confusion between these two products. Confusion between the antibiotic (Levofloxacin) and the anticonvulsant (Levetiracetram) could lead to serious adverse drug events
miFEPRIStone (Mifeprex) – misoprostol (Cytotec)	Confusion between mifepristone used for termination of pregnancy and misoprostol used for cervical ripening procedure could lead to serious adverse effects.
OxyCONTIN OxyCODONE	Similarity in names can lead to confusion between these two products. Oxycontin is sustained release and oxycodone is immediate release. Significant overdose could occur if the immediate release product is used in a dose appropriate for the controlled release medication.
quiNINE quiNIDine	Similarity in names can lead to confusion between these two products.
Platinol (CISplatin) Paraplatin (CARBOplatin)	Similarity in names can lead to confusion between these two products. Carboplatin doses usually exceed the maximum safe dose of cisplatin. Severe toxicity or death may result.
rifAMPpin rifAXIMin	Similarity in names can lead to confusion between these two products. Confusion between the antibiotic (Rifampin) and the antibiotic/antibacterial/anti IBS drug (Ritaximin) could lead to serious adverse drug events
SOLU-Medrol DEPO-Medrol	These two drugs are the same medication (methylprednisolone) but are different formulations. Solumedrol is given IV while Depomedrol is a long acting form given IM, intra-articularly, or intralesionally. It cannot be given IV.
Sublimaze (fentaNYL) Sufenta (SUFentanil)	Sufentanil is approximately ten times more potent than Fentanyl. Confusion has resulted in respiratory depression.
TraMADol TraZODone	Similar names have resulted in medication errors. Confusion between the analgesic (Tramadol) and the antidepressant (Trazodone) could lead to serious adverse drug events.
Velban (vinBLAStine) Oncovin (vinCRIStine)	Fatal errors have occurred, due to name similarity, when patients were mistakenly given vincristine intravenously, but at the higher vinblastine dose.

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