Medication Order for Infusion Services
Phone: 603-629-1828 to schedule appointment
Fax: 603-640-1949 to fax orders to Infusion Pharmacy

Infusion Services at Catholic Medical Center
Dartmouth Cancer Center, Notre Dame Pavilion
87 McGregor St, Suite 4100, Manchester, NH 03102

Patient Name:____Date:________________________________

Patient Phone #:____DOB:________________________________

Allergies/Intolerances:__________________________________ Height:_____□Cm □ Inches, Weight:_______□Kg □Lbs

Diagnosis:___________________________Insurance:________________________Prior Auth: Y/N_____# if known

Premedications: x1 dose

□Acetaminophen _______mg PO

□Diphenhydramine _____mg PO

□Diphenhydramine ______mg IV

□Loratidine 10mg oral

□Hydrocortisone _______mg IV

□Other:____________________

□May repeat above ordered pre-medications for Infusion Reaction

Rituxan™ (Rituximab)

1000mg IV on Days 1 & 15

Infuse per Protocol

Premedication: Days 1 & 15

□Diphenhydramine 25mg IV

□Diphenhydramine 50mg IV

□Methylprednisolone 100mg IV

□Other_________________

Medication Orders

□ Zoledronic Acid (Reclast™) 5mg IV over 30 minutes***

□ Ibandronate (Boniva™) 3mg IV Push over 30 seconds every 3 months x_____doses***

□ Denosumab (Prolia™) 60mg subcutaneously every 6 months x_____doses.

□ Belimumab (Benlysta™) ________mg IV over 1 hour every 4 weeks x_____doses.

□ Abatacept (Orencia™) _________mg IV in 100ml NS over 30 minutes every ____ weeks x _________doses

□ Natalizumab (Tysabri™) 300mg IV every 4 weeks x _______doses

□ Valproic Acid (Depacon™) ____________mg **or** __________mg/kg IV over 60 minutes x_____doses

□ Immune Globulin (IVIG) _______________grams IV every___________________________ x ______ doses. (will be rounded appropriately for package size)

□ Methylprednisolone IV (Solu-Medrol™) 1 gram in 250ml D5W. Infuse per Infusion Policy x_______doses

□ Omalizumab (Xolair™) ________mg subcutaneously every _________ weeks x_____doses

***Serum Creatinine, Serum Calcium & Serum Albumin required pre-treatment within 4-6 weeks of treatment. Fax results or Lab order.

All orders expire after 1 year from date written.

Other Medication orders or Hydration Order:

____
____
____
____
____
____
____

In order to complete our medical records, please verify your patient's status in regards to the following:
Special equipment needed during appointment:____
Cardiac/Pulmonary status:____ O2 dependent: Yes or No , _______Liters/min
Interpreter Needed: Yes or No Language:____________________

Follow Up discharge orders (Plan of Care): ______ Call Provider with update _______ Discharge Home
Referring Provider Signature:_________________________________ Print Name:__________________
Date:____ Time:______________________________
Office Phone number:_____________________________ Office Fax Number:______________________

Thank you for choosing Infusion Services at CMC, located at Dartmouth Cancer Center Manchester

Created/Revised Date: 9-2022
Approved by P&T/MEC: 9-2022
Responsible Department: Infusion Center