Medication Order for Infusion Services
Phone: 603-629-1828 to schedule appointment
Fax: 603-621-4938 to fax orders to Infusion Pharmacy

Infusion Services at Catholic Medical Center
(Dartmouth-Hitchcock NCCC) 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_____

Other Medication orders or Hydration Order:

_____

_____

_____

_____

_____

_____

_____

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.

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-Hitchcock's Norris Cotton Cancer Center

Created/Revised Date: 6-2008, 2-2015
Approved by P&T/MEC: 6-2008, 2-2015
Responsible Department: Infusion Center