

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

<p><u>Premedications: x1 dose</u></p> <p><input type="checkbox"/> Acetaminophen _____mg PO</p> <p><input type="checkbox"/> Diphenhydramine _____mg PO</p> <p><input type="checkbox"/> Diphenhydramine _____mg IV</p> <p><input type="checkbox"/> Loratidine 10mg oral</p> <p><input type="checkbox"/> Hydrocortisone _____mg IV</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> May repeat above ordered pre-medications for Infusion Reaction</p>	<p><u>Rituxan™ (Rituximab)</u></p> <p>1000mg IV on Days 1 & 15</p> <p>Infuse per Protocol</p> <p>Premedication: Days 1 & 15</p> <p><input type="checkbox"/> Diphenhydramine 25mg IV</p> <p><input type="checkbox"/> Diphenhydramine 50mg IV</p> <p><input type="checkbox"/> Methylprednisolone 100mg IV</p> <p><input type="checkbox"/> Other _____</p>	<p><u>Medication Orders</u></p> <p><input type="checkbox"/> Zoledronic Acid (Reclast™) 5mg IV over 30 minutes***</p> <p><input type="checkbox"/> Ibandronate (Boniva™) 3mg IV Push over 30 seconds every 3 months x _____doses***</p> <p><input type="checkbox"/> Denosumab (Prolia™) 60mg subcutaneously every 6 months x _____doses.</p> <p><input type="checkbox"/> Belimumab (Benlysta™) _____mg IV over 1 hour every 4 weeks x _____doses.</p> <p><input type="checkbox"/> Abatacept (Orencia™) _____mg IV in 100ml NS over 30 minutes every _____ weeks x _____doses</p> <p><input type="checkbox"/> Natalizumab (Tysabri™) 300mg IV every 4 weeks x _____doses</p> <p><input type="checkbox"/> Valproic Acid (Depacon™) _____mg or _____mg/kg IV over 60 minutes x _____doses</p> <p><input type="checkbox"/> Immune Globulin (IVIG) _____grams IV every _____ x _____doses. (will be rounded appropriately for package size)</p> <p><input type="checkbox"/> Methylprednisolone IV (Solu-Medrol™) 1 gram in 250ml D5W. Infuse per Infusion Policy x _____doses</p> <p><input type="checkbox"/> Omalizumab (Xolair™) _____mg subcutaneously every _____ weeks x _____doses</p> <p>***Serum Creatinine, Serum Calcium & Serum Albumin required pre-treatment within 4-6 weeks of treatment. Fax results or Lab order.</p> <p>All orders expire after 1 year from date written.</p>
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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-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