Comanche County Memorial Hospital

Outpatient Infusion Center Rituxan Order

Please fax form to: 580-585-5472

Patient Information

Patient Name: DOB: Phone: Gender ☐ M ☐ F

Patient Address: Email: Insurance:

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs

☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ C85.90 Non- Hodgkin Lymphoma, Unspecified, Unspecified Site

☐ C91.0 Acute Lymphoblastic Leukemia (ALL)

☐ C91.1 Chronic Lymphocytic Leukemia of B-Cell Type

☐ G70.00 Myasthenia Gravis (gMG) without Acute Exacerbation

☐ L10.0 Pemphigus Vulgaris

☐ M05.89 Other Rheumatoid Arthritis with Rheumatoid Factor of Multiple Sites

☐ M06.09 Rheumatoid Arthritis without Rheumatoid Factor, Multiple Sites

☐ M06.89 Other Specified Rheumatoid Arthritis, Multiple Sites

☐ M06.9 Rheumatoid Arthritis, Unspecified

☐ M31.30 Wegener's Granulomatosis without Renal Involvement

☐ M31.31 Wegener's Granulomatosis with Renal Involvement

☐ M31.7 Microscopic Polyangitis

☐ Other DX: _____

Clinical Information:

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation

☐ Patient Weight: _____ lbs/_____ kg ☐ Patient Height: _____ in/ _____ cm

☐ Allergies: _____

☐ Therapies Tried and Failed: _____

☐ TB Test: Date: _____ Results: _____ ☐ Hep B Test: Date: _____ Results: _____

☐ Does the patient have venous access? Yes or No If yes, What type? _____

If no, Initiate IV access

Lab Orders

☐ CBC ☐ CMP ☐ ESR ☐ CRP ☐ HBsAg ☐ HBsAB ☐ HBcAB

☐ Quantiferon Gold

☐ Other: _____

Lab Orders to be done by

☐ Infusion Services

☐ Referring Provider

Pre-Medications

☑ Benadryl _____ mg PO IVP once 30 min prior to infusion

☑ Acetaminophen _____ mg PO IVPB once 30 min prior to infusion

☑ Methylprednisolone _____ mg PO IVP once 30 min prior to infusion

Prescription Information

☐ Rituxan

☐ Dose and Frequency: 1000 mg days 0 and 14; then repeat course every _____ weeks (not sooner than every 16 weeks)

☐ Dose and Frequency: 375mg/m² every week for _____ weeks

☐ Dose and Frequency: _____ mg/m² every _____ for _____

☐ Dose and Frequency: _____ mg every _____ for _____

☐ Dose and Frequency: Other _____

Misc Orders

☑ PICC/ Midline/ CAD dressing to be changed every 7 days.

☐ _____

☐ _____

Flushes

☑ 10mL NS Flush Syringe PRN

☑ Heparin 500units/5mL Flush Syringe PRN

☑ 50ml NS Bag PRN

☑ 250ml NS Bag PRN

Standing Orders for Adverse Reactions

☑ Stop infusion and initiate NS bolus

☑ Notify Supervising physician and ordering provider

☑ Solu-Cortef 100mg SIVP signs of adverse reaction

☑ Benadryl 25mg SIVP for hives or bronchial inflammation

☑ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis

☑ Oxygen 2-5L nasal cannula

☑ Albuterol 2.5mg inhaled PRN for chest tightness

☐ Other: _____

Prescriber Information

Physician Name: _____ Office Contact Name: _____

Contact #: _____ Fax Number: _____

Address: _____ City/State/Zip: _____

NPI#: _____ DEA#: _____ State License #: _____

_____ _____

Physician's Signature Date Time