

DEMOGRAPHICS

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: ____/____/____ ☐ Male ☐ Female

Phone: _____

SSN: _____ Ht: _____ Wt: _____

PRESCRIBING PHYSICIAN

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

License#: _____

DEA#: _____ NPI: _____

ALLERGIES / REACTIONS

Signature: _____

Date: _____

PHYSICIAN ORDERS

☐ **RITUXAN**

REFILLS: _____

☐ Infuse 1000 mg on Day 1 and Day 15; Repeat every _____ months

☐ Infuse 1000 mg IV every _____ months

☐ **IV ACCESS**

☐ Peripheral IV - Flush with Normal Saline 5-10 ml with IV start and before & after medication

☐ Subcutaneous Port - Flush with Normal Saline 10 ml before & after medication---LOCK with Heparin 500 units (100 units/ml)

☐ **PRE-MEDICATIONS / LABS**

REFILLS: _____

☐ Diphenhydramine _____ MG IV 30 minutes before infusion ☐ Solu-Medrol _____ MG IV 30 minutes before infusion

☐ OTHER: _____

☐ LABS: _____ FREQUENCY _____

☒ **Anaphylaxis Kit per Pharmacy protocol**

TO BE ADMINISTERED BY THE HEALTH CARE PROVIDER PRN FOR PATIENTS RECEIVING IV MEDS IN THE HOME

Epinephrine Auto Injector 0.3mg/0.3ml IM - Repeat one time in 20 minutes if needed

☒ **ADVERSE REACTION ORDERS:**

Mild Reactions - Reduce rate by 1/2 at time of onset and keep reduced x30 minutes. If resolved, increase per guidelines. If not resolved, administer appropriate medication based on symptoms,

Severe Reactions - STOP infusion ☒, KVO IV Normal Saline ☒ Diphenhydramine 25/50 mg IVP over 3-5 minutes ☒

Methylprednisolone 125 mg IVP over 5 minutes ☒ Call Ambulance and Physician ☒.

DIAGNOSIS:

☐ M06.9 Rheumatoid Arthritis ☐ M08.0 Juvenile Rheumatoid Arthritis ☐ L40.50 Psoriatic Arthritis

☐ M45.9 Ankylosing Spondylitis ☐ Other: _____