Northern Light Health

☐ NL Infusion Care, AR Gould, **Presque Isle**
Phone: 207-768-4589; Fax: 207-768-4183
☐ NL Infusion Care, **Blue Hill**
Phone: 207-374-3995; Fax: 207-374-3970
☐ NL Infusion Care, CA Dean, **Greenville**
Phone: 207-695-5222; Fax: 207-695-4801
☐ NL Infusion Care, **Brewer**
Phone: 207-973-9785; Fax: 207-973-9788
☐ NL Infusion Care, **Waterville**
Phone: 207-861-3380; Fax: 207-861-3348
☐ NL Mary Dow Center, **Ellsworth**
Phone: 207-664-5584; Fax: 207-664-5485
☐ NL Infusion Care, Mayo, **Dover-Foxcroft**
Phone: 207-564-4254; Fax: 207-564-4418
☐ NL Mercy Cancer Care, **Portland**
Phone: 207-553-6868; Fax: 207-904-0917
☐ NL Infusion Care, SVH, **Pittsfield**
Phone: 207-487-4052; Fax: 207-487-3995

PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

OP rituximab (Rituxan) (Paper)

Diagnosis: _____ **ICD10:** _____

Hepatitis and Tuberculosis Serologies Completed: ***Note:** *If NO, treatment will not be scheduled until results are available.*

Hepatitis B: Yes ☐ No ☐ Date:____/____/____ Result: _____
Hepatitis C: Yes ☐ No ☐ Date:____/____/____ Result: _____
Quantiferon TB Gold Test OR T SPOT: Date:____/____/____ Which test: _____Result: _____

IV Access:

☐ Saline Lock:
- ☑ Insert peripheral Saline Lock; *may leave in for consecutive treatment days*
- ☑ Discontinue Saline Lock after therapy completed

☐ PICC Line:
- ☑ Routine PICC Line Care, labs and restoration
- ☐ Discontinue PICC Line (verify regimen is complete with provider prior to removing line)

☐ Porta cath / Central Access Device (Hickman, Triple lumen):
- ☑ Porta cath access, labs, restoration, and de-access / Central Access Device use and care

Height: _____ cm **Weight:** _____ kg **BSA:** _____ m2

Premedication:

☑ acetaminophen (Tylenol) *650 mg, Tablet, PO, ONCE*
☑ cetirizine (ZyrTEC) *10 mg, Tab, PO, ONCE*
☑ famotidine (Pepcid) *20 mg, Tab, PO, ONCE*
☐ methylPREDNISolone *40 mg, Soln, IVP, ONCE*
☐ methylPREDNISolone *125 mg, Soln, IVP, ONCE*
☐ methylPREDNISolone _____ *mg, Soln, IVP, ONCE*

PRN Medication:

☐ meperidine (Demerol) *25 mg, Soln, IVP, PRN chills, may repeat X 1 in 15 minutes*

Medication: Please indicate specific brand of medication/biosimilar if medically indicated. If not, NLH's preferred biosimilar will be used to fulfill this order.

☐ Wait for lab results before infusing riTUXimab
☐ riTUXimab *(flat dose) 1000 mg, Soln, in 250 mL 0.9% Sodium Chloride, IVPB*
☐ riTUXimab *(flat dose) 1000 mg, Soln, in 250 mL 0.9% Sodium Chloride, IVPB, Day 0 and day 14*
☐ riTUXimab *(flat dose) 500 mg, Soln, in 250 mL 0.9% Sodium Chloride, IVPB*
☐ riTUXimab *(flat dose) 500 mg, Soln, in 250 mL 0.9% Sodium Chloride, IVPB, Day 0 and day 14*
☐ riTUXimab *375 mg/m2 = _____ mg Soln, in 250 mL 0.9% Sodium Chloride, IVPB*
☐ riTUXimab _____ *mg/m2 = _____ mg Soln, in 250 mL 0.9% Sodium Chloride, IVPB*

Repeat: ☐ *Weekly*
☐ *Every _____ weeks*
☐ *In _____ months*
Duration: _____ ☐ *Doses/Times* ☐ *Weeks* ☐ *Months*

Other: _____

_____

_____

Date: _____ Time: _____
Provider Signature: _____ Print Name: _____
Phone: _____ Fax: _____
Pharmacy Signature: _____

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PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS
September 2024