



DOCORD

DOCTOR'S ORDER SHEET
DEPARTMENT OF INFUSION SERVICES
INTRAVENOUS RiTUXImab

Side 1 of 2

Instructions:

- 1. Do not return charts with new or changed orders to rack.
2. Mark requested orders and/or boxes if indicated.
• Pre-marked box orders will be performed unless otherwise noted.
• No conditional (dependent on the approval of another physician) medication orders will be honored.

DOCTOR'S ORDER REQUISITIONED NOTED

\*This order form is not valid for prescribing of controlled substances\*

Instructions: Fax the below information

- 1. Completed and signed doctor's order sheet form (please include all pages)
2. Patient demographics including insurance information
3. Once all items are reviewed ChristianaCare Infusion Services will reach out to your patient to schedule

• Phone: 302-733-1548
• Access coordinator: 302-733-1553
• Fax: 302-733-1561

- ☐ New Referral
☐ Order Renewal
☐ Medication/Order Change

Date: \_\_\_/\_\_\_/\_\_\_
Patient name:
DOB: \_\_\_/\_\_\_/\_\_\_
Allergies:
Weight [kg or lb (mark one)]: \_\_\_ Date: \_\_\_/\_\_\_/\_\_\_
ICD 10:

- ☐ Insurance Authorization/Prior Auth number:
☐ If no insurance authorization needed provide confirmation/reference number: \_\_\_\_\_

1) Pre-Medications:

- A. ☐ Acetaminophen (e.g. Tylenol®) 650 mg PO once 30 minutes prior to infusion
B. ☐ DiphenhydrAMINE (e.g. Benadryl®) 50 mg PO once 30 minutes prior to infusion
C. ☐ Hydrocortisone (e.g. Solu-CORTEF®) \_\_\_ mg IV once 30 minutes prior to infusion
OR
☐ MethylPREDNISolone (e.g. SOLU-Medrol®) \_\_\_ mg IV once 30 minutes prior to infusion
D. ☐ Other (must include medication, dose, route and frequency): \_\_\_\_\_

2) RiTUXImab (e.g. Rituxan®)

- ☐ 1000 mg IV on weeks 0, 2 for a total of 2 doses
☐ 375 mg/m² IV weekly for a total of \_\_\_ doses
☐ Other (must include medication, dose, route, frequency and duration): \_\_\_\_\_
\*orders will be honored for a max of 6 months\*
Note: Pharmacist will dose on actual body weight unless otherwise specified. Doses will be rounded to nearest vial size.

3) Additional orders: \_\_\_\_\_

Signature/Title

Contact phone #

Print Name or ID#

Date

Time

**DOCTOR'S ORDER SHEET**  
**DEPARTMENT OF INFUSION SERVICES**  
**INTRAVENOUS RiTUXimab**

Side 2 of 2

<b>Key:</b>	BID - Twice daily	MD - Maintenance dose
	D5W - Dextrose 5% in water solution	mg - Milligram
	D/C - Discontinue	min - Minute
	DOB - Date of birth	mL - Milliliter
	HOH - Hard of hearing	ng - Nanogram
	hr - Hour	NPO - Nothing by mouth
	ICD - International Classification of Diseases	NS - 0.9% sodium chloride
	IM - Intramuscular	NSS - Normal saline solution
	IV - Intravenous	PCA - Patient controlled analgesia
	kg - Kilogram	PO - By mouth
	L - Left	PRN - As needed
	LD - Loading dose	R - Right
	LR - Lactated ringers	TID - Three times daily
	mcg - Microgram	X - Times