

**BEAUMONT INFUSION CENTERS
NEPHROLOGY PRESCRIPTION**

Location / Royal Oak : 248- 551-3168 Troy : 248-964-2409 Lenox : 947-523-4061 Wayne : 734-467-2505
 Fax Number Grosse Pointe : 586-498-4497 Farmington Hills : 248-471-8217 Dearborn : 313-593-5802 Livonia : 734-542-3356

Patient Name:	Date of Birth:	Medical Record #:
Physician Name:	Address:	Office #:
Diagnosis:	Diagnosis Code (ICD-10):	

PATIENT INFORMATION			
Please attach these <u>required</u> documents to Prescription (if not in EPIC):			
<input checked="" type="checkbox"/>	Copy of Insurance Card	<input checked="" type="checkbox"/>	Labs
<input checked="" type="checkbox"/>	Supporting clinical documentation	<input checked="" type="checkbox"/>	Patient Demographics
<input type="checkbox"/>	NKDA		
<input type="checkbox"/>	Drug Allergies: _____		
Height:	_____ ft _____ in	Weight:	_____ kg / lbs
Date:	_____		

REQUIRED LABS FOR THERAPY: To be Ordered By Referring Physician Office
Rituximab: Hepatitis B screening completed and patient is clear to receive treatment Yes No
Procrit/Aranesp: Hgb & HCT required prior to each appointment and within 48 hours of therapy. Office will need to provide patient with a prescription for labs to be drawn.
 For CKD patients not on dialysis and oncology patients (oncology indications), if Hgb is 10 g/dL or greater, the dose is held per protocol.
 For CKD patients on dialysis, if Hgb is 11 g/dL or greater, the dose is held per protocol.

MEDICATION	DOSE	# Doses
DARBEPOETIN (ARANESP)	_____ mcg SQ every _____ weeks	
EPOETIN ALFA (PROCRIT)	<input type="checkbox"/> 20,000 units SQ or <input type="checkbox"/> 40,000 units SQ every _____ weeks	
RITUXIMAB (RITUXAN)	375 mg/m ² x _____ (BSA) = _____ mg IV once weekly x 4 weeks. <ul style="list-style-type: none"> • 1st infusion: Initiate at 50mg/hour. If no reaction, increase to 50mg/hr every 30 minutes to a maximum of 400mg/hour. • Subsequent Infusions: If no reaction on first infusion, infuse at 100mg/hour and increase by 100mg/hour every 30 minutes to a maximum infusion rate of 400mg/hour. Pre-Medications: <input type="checkbox"/> Acetaminophen <input type="checkbox"/> 325mg, <input type="checkbox"/> 500 mg, <input type="checkbox"/> 650 mg, <input type="checkbox"/> 1000 mg PO 30 minutes prior to infusion. <input type="checkbox"/> Diphenhydramine 25mg PO 30 minutes prior to infusion. <input type="checkbox"/> Methylprednisolone 100 mg IV 30 minutes prior to infusion.	
<ul style="list-style-type: none"> • Adult Anaphylaxis Protocol • Notify physician if reaction occurs 		

Physician Signature _____ Beeper # _____ Date _____ Time _____