BEAUMONT INFUSION CENTERS
NEPHROLOGY PRESCRIPTION

Location: ☐ **Royal Oak FAX: 248- 551-3168** ☐ **Troy FAX: 248-964-2409** ☐ **Wayne FAX: 734-467-2505** ☐ **Lenox FAX: 947-523-4061**
☐ **Grosse Pointe FAX: 586-498-4497** ☐ **Farmington Hills FAX: 248-471-8217** ☐ **Dearborn FAX: 313-593-8551**

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

PATIENT INFORMATION

Please attach these *required* documents to Prescription (if not in EPIC):

● Copy of Insurance Card ● Labs ● Supporting clinical documentation ● Patient Demographics

☐ **NKDA**

☐ **Drug Allergies:** _____

Height: _____ ft _____ in **Weight:** _____ kg / lbs **Date:**_____

REQUIRED LABS FOR THERAPY: To be Ordered By Referring Physician Office

Rituxan: Hepatitis B Screen (Surface antigen and core total antibody required) Date of Test: _____ Result:_____

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)	☐ 20,000 units SQ **or** ☐ 40,000 units SQ every _____ weeks	
RITUXIMAB (RITUXAN)	375 mg/m2 x _____ (BSA) = _____ mg IV once weekly x 4 weeks. • 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: ☐ Acetaminophen ☐ 325mg, ☐ 500 mg, ☐ 650 mg, ☐ 1000 mg PO 30 minutes prior to infusion. ☐ Diphenhydramine 25mg PO 30 minutes prior to infusion. ☐ Methylprednisolone 100 mg IV 30 minutes prior to infusion.	

- Adult Anaphylaxis Protocol
- Notify physician if reaction occurs

Physician Signature _____Beeper # _____ Date _____ Time_____