Edward-Elmhurst HEALTH | Healthy Driven

Edward Cancer Centers
120 Spalding Drive; Suite 111; Naperville, IL 60540
Phone: 630/527-3788 Fax: 630/548-6617

24600 West 127th Street; Plainfield, IL 60585
Phone: 630/527-3788 Fax: 630/548-6617

Rituxan Infusion Therapy Orders

Patient Name: _____ DOB: _____

*****Please include current history and physical and any recent labs/tests, if applicable*****

PLEASE ATTACH COPY OF INSURANCE CARD WITH THIS ORDER

Pre-Authorization # or Call Reference #: _____

(Ordering Physician Office is Responsible to Obtain Authorization/Referral)

☐ **Check if insurance requires drug to be provided by specialty pharmacy**

Contact Name and Phone Number of Insurance Company: _____

If you have any questions regarding pre-authorizations, please contact (630) 527-3788 and ask for the billing department.

Diagnosis (ICD-10 Required): _____

Weight (lbs/kg): _____ Height: _____

Is this their first dose? ☐ Yes ☐ No Date of Previous Dose: _____

Pre-Infusion Requirements

This patient must have a current CBC/differential done within 48 hours of treatment.

Lab results to be faxed prior to treatment ☐ Yes ☐ No

Draw CBC/differential at Cancer Center day of treatment. ☐ Yes ☐ No

Dose: _____ mg/m^2 = _____ mg

Frequency: _____

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Pre-Medications: (Please mark all that apply)

- ☐ Tylenol 650mg po prior to infusion
- ☐ Benadryl 25mg IVPB prior to infusion
- ☐ Benadryl 25mg po prior to infusion

In the event of a hypersensitivity reaction during the infusion of this medication, we will implement the reaction protocol. A designated nurse practitioner will evaluate your patient and your office will receive notification of the event.

Physician Signature: _____ **Date:** _____

Ordering Physician NPI: _____ **Edward Hospital NPI:** **1427069632**

_____	_____	_____
Physician Name (Please Print)	**Office Phone**	**Fax Number**

Revision/Review Date: 02/23/18