MIC | METRO INFUSION CENTER

Rituximab and hyaluronidase human (Rituxan Hycela®)

Name: _____
DOB: _____
Diagnosis/Code: _____/ _____
Cancer Stage/line of tx:_____/_____

Flat Dose **BSA:** N/A

Patient clearance: ☐ **Submit patient consent**

Patient will be seen by oncology prior to every _____ cycle/week and cleared (MIC staff will assess prior to each dose)

Laboratory or other tests related to treatment that should be completed within _____ of treatment by referring prior to clearance for infusion:

Will be done at referring office (***Name and Phone# of who to expect labs from***):_____

☐ CBC with each treatment ☐ Other: _____

Dosing Guidelines/Parameters: ***Provider must select hold parameters that will trigger a call from the Infusion staff***

☐ Hold and call provider for ANC: _____ /Platelet: _____

☐ No hold for ANC/Plt ☐ Hold for active infection

Hydration Orders:

Premedication P*rovider to select requirements below:*

☐ No premeds needed (patient has tolerated well without any premeds in the past)

DRUG	DOSE	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN
☐ Diphenhydramine	25mg	☐ IV ☐ PO		1 hour to 3 hours before every DARZALEX infusion
☐ Acetaminophen	650mg	PO	_____	1 hour to 3 hours before every DARZALEX infusion
_____Steroid	_____mg			

Treatment orders:

DRUG	DOSE CALCULATION DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES
☐ Patient HAS had at least one full dose of a rituximab product by intravenous infusion without reaction					
☐ Rituximab and hyaluronidase (Rituxan Hycela®)	1,400 mg rituximab plus 23,400units hyaluronidase	11.7ml	SQ	5 minutes**	_____
☐ Rituximab and hyaluronidase (Rituxan Hycela®)	1,600 mg rituximab plus 26,800units hyaluronidase	13.4ml	SQ	7 minutes**	_____

**Observe for 15 minutes post injection

Date of intended first treatment at Metro Infusion Center: _____

Subsequent treatment may be given +/- 2 days or as otherwise specified:

This order is good for 1 year from the date ordered

Other:

Oral/other cancer treatment patient is taking: _____

Call referring provider for:

Date:

Referring Provider: _____ _____ Phone# _____

SIGNATURE REQUIRED **PRINTED NAME REQUIRED**

All information in this order is strictly confidential and will become part of the patient's medical record. Contact us with questions at (877)448-3627. Send completed form and all documentation to confidential email: MICreferral@metroinfusioncenter.com or fax to (866)507-1164.

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