

Continuation of Therapy:

Dosing: IV 600mg

Duration: **Option 1:** Start at 40mL/hr, increasing by 40mL every 30 minutes if tolerated, with max rate of 200mL/hr

Option 2: Start at 100mL/hr for 15min, if tolerated increase to 200mL/hr for 15 minutes then increase to 250mL/hr for 30 min and if continues to tolerate can increase rate to 300mL/hr for the remaining 60 minutes.

Frequency: Every 6 months

Route: Peripheral IV per protocol PICC capping per protocol PORT capping per protocol

Date of last infusion: _____

Vitals: Monitor baseline vital signs, with each infusion rate change, then hourly once maximum rate has been achieved and post infusion

Other: _____

REFERRING PROVIDER INFORMATION

For questions regarding patient's care during the infusion, please contact:

Facility: _____ Fax: _____

Name 1st Point of Contact (must be available during infusion): _____

Phone: _____

Name 2nd Point of Contact (must be available during infusion): _____

Phone: _____

By referring to the Medical Associates Infusion Clinic, it is recognized and agreed upon that the referring specialist or delegate listed above will be available and responsive during the duration of the scheduled infusion appointment. This contact should be available to answer any questions and/or address concerns related to the care of the patient. The on-site provider within the Infusion Clinic will be responsible for urgent patient care needs during the infusion.

Ordering Provider Name (please print): _____

Ordering Provider Signature: _____ Date: _____

FAX NUMBER: 563-584-4232

PHONE NUMBER: 563-584-4370

Order valid for 1 year from date of signature unless otherwise specified.