Palmetto INFUSION

Phone: 800-809-1265

MRN:_____

Standard Mitoxantrone HCL Plan of Treatment

Patient Name:_____Height:_____Weight:_____

Allergies:_____

Primary Diagnosis:_____Secondary Diagnosis_____

ORDERS:

Premedicate with (Check all that apply):

☐ 30 Minutes prior to infusion ☐ 60 Minutes prior to infusion

☐ Prochlorperazine 10 mg PO ☐ Granisetron HCL 1mg PO

☐ Ondansetron HCL __ 8mg_ 16mg or___24mg PO☐ Dexamethasone 10 mg IV over 10-15 minutes

☐ Ondansetron HCL 10 mg IV over 15-30 minutes ☐ Other: _____

If adverse drug reaction occurs, Implement the Standing Adverse Reaction Protocol.

DRUG:

Mitoxantrone HCL_____MG IV to infuse over 30 minutes every_____months.

Labwork:

_____CBC with Diff, LFT's (OT,PT, Total Bilirubin) 1 week prior to infusion.

_____CBC With Diff, LFT's (OT, PT, Total Bilirubin) 7-10 days after infusion.

Special Orders:

If client is female and capable of becoming pregnant, has she had a pregnancy test?

☐ Yes: Date and Results_____☐ No

Has client had an ECG and ECHO prior to first dose of Mitoxantrone HCL? ☐ Yes ☐ No

If client has had 4(four) doses of Mitoxantrone HCL has a repeat ECG and ECHO been done? ☐ Yes ☐ No

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(No Stamped Signatures, Please)

Physician's Signature:_____/_____Date: _____

(Dispense as written) (Substitution permitted)

Print Physician Name:_____

Please fax completed form, along with Demographics and Insurance Information

866-872-8920