Princeton / Somerset New Jersey
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ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

REJUVEINATE

INFUSION ORDERS
RITUXIMAB

Date: ____________________

PATIENT INFORMATION

☐ Demographics attached

Patient Name: ______________________________ DOB: __________ Phone: ______________________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

J Code: J9312
Patient Weight: __________ lbs. Allergies: ______________________________

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached
☐ **Required Labs:** CBC w/ platelet, Hepatitis B antigen, Hepatitis B core total antibody
☐ **Recommended Labs:** Quantitative immunoglobulins (IgM, IgG, and IgA), Hepatitis C Virus, TB Test

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician
Lab Orders: ______________________________

RITUXIMAB INFUSION ORDERS

SELECT BRAND: ☐ **RITUXAN** ☐ **TRUXIMA** ☐ **RUXIENCE**

Diagnosis: ☐ Rheumatoid Arthritis (ICD-10 __________) ☐ Other:____________________(ICD-10__________)
(RA) **Dose:** ☐ 1000mg **Dose Frequency:** ☐ Day 0, repeat dose in 2 weeks
☐ One time dose

Diagnosis: ☐ Granulomatosis w/ Polyangiitis (ICD-10 __________) ☐ Microscopic Polyangiitis (ICD-10 __________)
(GPS/MPA) **Dose:** ☐ 375mg/m2 - **Dose Frequency:** ☐ weekly x 4 weeks ☐ Other: __________________
☐ 500mg - **Dose Frequency:** ☐ Day 0, repeat dose in 2 weeks ☐ Other: __________________

Diagnosis: ☐ Pemphigus Vulgaris (ICD-10 __________)
(PV) **Dose:** ☐ Initial Dose: 1000mg IV **Dose Frequency:** ☐ Day 0, repeat dose in 2 weeks
☐ Maintenance Dosing: 500mg IV ☐ Every 6 months

Diagnosis: ☐ Other: ____________________ (ICD-10__________)
(Other) ☐ Other: ____________________ (ICD-10__________)
Dose: ☐ 1000mg ☐ 500mg ☐ 375mg/m2 ☐ Other: ____________________
Dose Frequency: ☐ One Dose ☐ Day 0, repeat dose in 2 weeks ☐ Other: ____________________

Protocol Pre-Medication: Solu-Medrol 100mg IV, Tylenol 1000mg PO, Benadryl 50mg PO/IV
☐ Other: ______________________________

Order Frequency: ☐ One time order, no refills
☐ Repeat ordered dose every ________week(s) **OR** ________ month(s) **X** ________ dose(s)

Additional Orders/Comments:

ORDERING PROVIDER

Signature **X** ______________________________ Date ____________________

Provider ____________________ Phone ____________________ Fax ____________________