

(rituximab)

RITUXAN infusion orders

Date: _____

Patient Name _____ DOB _____

Phone _____ ☐ Allergies M ☐ F ☐

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

REFERRAL STATUS

- ☐ New Prescription
☐ Order Renewal
☐ Does or Frequency Change
☐ Discontinuation

DIAGNOSIS Please provide ICD-10 code

☐ _____ Rheumatoid Arthritis

☐ _____ Granulomatosis w/Polyangitis
(wegener's granulomatosis GPA)

☐ _____ Microscopic Polyangitis

☐ _____
(other)

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ _____

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____

RITUXAN ORDERS

DOSAGE

☐ 1000mg

☐ 375mg/m²

☐ Other _____

FREQUENCY

☐ initial dose (0) followed by 2nd dose on day 15 (induction for RA diagnosis)

☐ single dose

☐ every week for 4 weeks total

☐ _____
(other frequency)

PATIENT WEIGHT

_____ lbs.

_____ kg

☐ Total dosages _____

☐ Refills _____

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____