(rituximab)

RITUXAN infusion orders

Patient Name _____ DOB _____

Phone _____ M ◯ F ◯

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Rheumatoid Arthritis

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

☐ _____ Microscopic Polyangiitis

☐ _____ _____
(other)

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ _____

☐ Length of Need _____

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____

RITUXAN ORDERS

DOSAGE

◯ 1000mg

◯ 375mg/m^2

PATIENT WEIGHT

_____ lbs.

_____ kg

FREQUENCY

◯ intial dose (0) followed by 2nd dose on day 15 *(induction for RA diagnosis)*

◯ single dose

◯ every week for 4 weeks total

◯ Refills: _____

◯ _____
(other frequency)

Notes

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Address _____

_____

NPI# _____

DEA# _____

FAX ORDERS: 702-780-4887