

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



Office: 212-803-3339 Fax: 646-768-8600

(rituximab)

RITUXAN infusion orders

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

DIAGNOSIS *Please provide ICD-10 code*

_____ Rheumatoid Arthritis

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

_____ Microscopic Polyangitis

(other)

PRE-MEDICATION

Tylenol 1000mg PO Solu-Medrol 125mg IVP

Diphenhydramine 25mg PO Solu-Cortef 100mg IVP

Cetirizine 10mg PO Diphenhydramine 25mg IVP

(other) _____
(other)

RITUXAN ORDERS

PATIENT WEIGHT

_____ lbs.

_____ kg

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)*

Total dosage /refills _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____