Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830

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

(rituximab)

RITUXAN infusion orders

Date: ________________

PATIENT INFORMATION		
Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS
☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐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
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ ____________________ *(other)*
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ ____________________ *(other)*

RITUXAN ORDERS

PATIENT WEIGHT

__________ lbs.

__________ kg

DOSAGE:

- ☐ 1000mg
- ☐ 375mg/m²
- Other____________________

Frequency:

- ☐ Intial 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 ____________