

Lexington
1792 Alysbeba Way
Suite 205
Lexington, KY 40509

Bowling Green
727 U.S. 31 W Bypass
Suite 102
Bowling Green, KY 42101



(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 | ☐ 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 _____