

TN  
100 Covey Drive  
Suite 307  
Franklin, TN 37067



(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/m<sup>2</sup>

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 \_\_\_\_\_