Patient Name:______________________________________

DOB:_____________________ Wt(kg):_________________

Allergies:___________________ Phone:_________________

Truxima (Rituximab-abbs) Orders

Required Information:

- Signed order from prescribing provider
- Patient demographics including insurance information
- Supporting clinical documentation: Visit notes, diagnostic results
- Required Labs: TB & Hep B screening

Primary Diagnosis:

- Rheumatoid Arthritis (ICD-10 :_________)
- Granulomatosis with Polyangiitis (ICD-10:__________)
- Moderate to Severe Pemphigus Vulgari (ICD-10 :________)
- _________________________ (ICD-10:_________)

TRUXIMA ORDERS

Dose: Truxima 1000mg IV on days 1 and day 15

Frequency: Once Every 24 weeks

Dose: Truxima 500mg IV on days 1 and day 15

Frequency: Once Every 24 weeks

Dose: Truxima _____ mg IV

Frequency: ________________________

Administered per manufacturer guidelines

Date of Last Rituximab: ___________

PRE-MEDICATIONS

- PO Tylenol _____mg
- PO Cetirizine _____mg
- IV Solu-medrol _____mg
- PO Loratadine _____mg
- PO IV Diphenhydramine _____mg
- PO IV Other:______________ _____mg

LABS

CBC	ESR	Uric Acid
CMP	TB Quantiferon Gold	Other:______
CRP	Hep B Core/Surface AG	Other:______

Frequency: Every Visit / Every Other Visit / One time only / Other:____________

CPL Acct #:__________

ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

____

____

____

Physician Name:	**Phone:**	**Fax:**
Physician Signature:	**NPI:**	**Date:**