Patient Name:_____

DOB:_____ Wt(kg):_____

Allergies:_____ Phone:_____

RITUXAN (Rituximab)
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:_____)

RITUXAN ORDERS

Dose: ☐ Rituxan 1000mg IV on days 1 and day 15

Frequency: ☐ Once ☐ Every 24 weeks

Dose: ☐ Rituxan 500mg IV on days 1 and day 15

Frequency: ☐ Once ☐ Every 24 weeks

Dose: ☐ Rituxan _____ 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:**