RITUXAN (RITUXIMAB)
INFUSION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10 below)
- ☐ **Required Labs:** CBC, Hep B panel (HBsAg anti-HBc), Quantitative lmmunoglobulin (lgM, lgG and lgA): negative PPD or TB Gold; Anti-HCV antibody.

Patient Name:	DOB:
Allergies:	Patient Phone:

J Code: J9310

Rituxan Orders

Hepatitis B Protocol: Hep B surface antigen and Hep B Core AB total required.

***Date of last (select one): Remicade Orencia Humira Enbrel ____________**

Diagnosis: ☐ Rhuematoid Arthritis (ICD10_____________)
☐ Other (ICD10_____________)

OPTION 1: Rituxan dose: ☐ 1000 mg on day 1 and day 15
Frequency: ☐ One time dose only ☐ Every 24 weeks

(OR)

Diagnosis: ☐ Granulomatosis with Polyangiitis (ICD-10: ___________)
☐ Microscopic Polyangiitis (ICD-10: ___________)

OPTION 2: Rituxan dose: 375mg/M2
Frequency: Weekly x 4 weeks Other:_____________________

For severe vasculitis symptoms:

- ☐ Solu-Medrol 1000mg IV daily for ________ days (1-3 days) within 14 days prior to Rituxan infusion.
- ☐ Solu-Medrol infusion to be followed by oral prednisone taper of lmg/kg/daily (not to exceed 80mg daily)
- ☐ Prednisone Rx provided by prescribing provider

Protocol Pre-medication Orders: Tylenol l000mg PO **and** Benadryl 50mg PO/IVP

- ☐ Solu-Medrol l000 mg IVP (optional)

Additional Instructions:

Physician Name:	Phone:	Fax:

Physician signature:	Date: