SPECIALTY INFUSION CENTERS

RITUXAN ORDER FORM
(Rituximab)

FAX TO: 800-540-1852

PATIENT INFORMATION

Patient Name: ______________________ DOB: ______________ Phone: ______________ Sex: M / F

Ht: ____ WT: ____ lbs / kg Primary Language: ______________ Allergies: ________________

Patient Preferred Location: ☐ Staten Island ☐ West Harrison ☐ Manhattan ☐ New Paltz ☐ Bronx ☐ Syosset ☐ Port Jefferson ☐ Millburn ☐ Brooklyn Heights ☐ Paramus

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code (PROVIDE COMPLETE CODE)

☐ M06.9 Rheumatoid Arthritis
☐ M31.30 (Wegener's Granulomatosis GPA)
☐ M31.7 Microscopic Polyangitis
☐ G35
Other: ______________

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.
NOTE: Include negative Hepatitis B within 3 years.

PRESCRIPTION

Pre-Medications

☐ Tylenol 650mg PO ☐ Benadryl 25mg IVP ☐ Pepcid 20mg IVP
☐ Zyrtec 10mg PO ☐ Benadryl 50mg PO ☐ Solu-medrol 125mg IVP
☐ Claritin 10mg PO ☐ Benadryl 50mg IVP ☐ Solu-medrol 250mg IVP
☐ Benadryl 25mg PO ☐ Pepcid 20mg PO ☐ Solu-medrol 500mg IVP

Other: ______________

Pre Labs:

☐ CBC ☐ Iron Panel
☐ CMP ☐ Vitamin D
☐ CRP ☐ Other ______________
☐ ESR

Rituxan (rituximab)

Loading Dose:

☐ IV: infuse 1000 mg
☐ IV: infuse 375 mg/m2 – Required ➔ ☐ Height: _____,
Weight: ________ lbs or ________ kg

Frequency & Duration: (SELECT ONE)

☐ Infuse single dose
☐ Infuse every week for 4 weeks total
☐ Infuse initial dose at day 1 followed by 2nd dose on day 15, then repeat dose every ____ months for one year
☐ Other frequency: ____ for one year

In the event of an adverse reaction occurring at a Specialty Infusion suite, utilize the Specialty Infusion adverse reaction protocol.

Comments: ____

PRESCRIBER INFORMATION

Prescriber Name: ______________________ Signature:

Supervising Provider (if applicable) ______________________

Date: __________ NPI#: ______________ Specialty: ______________

Practice Name: ______________________________ (If Applicable)

Address: ______________ City: __________ State: ______ Zip: ______

Contact Name: ______________ Phone: ________ Fax: ________ Email: ____________