Rituxan Infusion Order

Fax 281-715-5302 Phone 281-265-0100

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

- ◯ M06.9 Rheumatoid arthritis, unspecified
- ◯ M05.79 Rheumatoid arthritis with rheumatoid factor without organ or systems involvement
- ◯ G36.0 Neuromyelitis Optica
- ◯ Other _____

ICD-10 _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

- ◯ Clinical/ Progress Notes
- ◯ Demographics Sheet
- ◯ Current Medications
- ◯ Labs

RITUXAN ORDER

Patients weight: _____ kg

Rituxan Dose:

- ◯ Initial/Reload Dosing: 1000 mg IV on day 0, day 14, then repeat the course every _____ weeks.
- ◯ Other Dosing: _____ mg/m2 IV every weekly for 4 weeks

PreMeds:

- ◯ diphenhydramine
- ◯ APAP
- ◯ IV methylprednisolone 100mg
- ◯ IV methylprednisolone 1000mg

Date of last Rituxan Infusion: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____