Local Infusion

MYLOCALINFUSION.COM

TRUXIMA (RITUXIMAB-ABBS) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____

DIAGNOSIS (Provider must specify)

❑ Rheumatoid Arthritis, ICD 10: M05._____ or M06._____
❑ Granulomatosis with Polyangiitis, ICD 10: M31._____
❑ Microscopic Polyangiitis, ICD 10: M31.7
❑ Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO
❑ Benadryl 25mg PO
❑ Famotidine 20 mg IV
❑ Cetirizine (Zyrtec) 10 mg PO
❑ Methylprednisolone (Solu-Medrol) 125 mg IVP
❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Truxima	❑ 500 mg ❑ 1,000 mg ❑ 375 mg/m2	❑ IV	❑ Day 0 and 14 x1 course ❑ Day 0 and 14, Repeat in 6 months ❑ Day 0, 7, 14, and 21 x1 course ❑ Other: _____

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❒ CT: 203.433.0621 ❒ ME: 207.407.7272 ❒ NH: 603.217.5371 ❒ NJ: 201.581.4521

Order valid for 1 year from date of signature unless otherwise specified here: _____