

RITUXAN (RITUXIMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____

DIAGNOSIS (Provider must specify)

- Rheumatoid Arthritis, ICD 10: M05.____ or M06.____
 Microscopic Polyangiitis, ICD 10: M31.7
 Granulomatosis with Polyangiitis, ICD 10: M31.____
 Pemphigus Vulgaris, ICD 10: L10.0
 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
 Famotidine 20 mg IV
 Methylprednisolone (Solu-Medrol) 125 mg IVP
 Benadryl 25mg PO
 Cetirizine (Zyrtec) 10 mg PO
 Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Rituxan	<input type="checkbox"/> 500 mg <input type="checkbox"/> 1,000 mg <input type="checkbox"/> 375 mg/m2	<input type="checkbox"/> IV	<input type="checkbox"/> Day 0 and 14 x1 course <input type="checkbox"/> Day 0 and 14, Repeat in 6 months <input type="checkbox"/> Day 0, 7, 14, and 21 x1 course <input type="checkbox"/> Other _____

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

LABS / SPECIAL INSTRUCTIONS