



Rituxan® (rituximab) Order Form

Please include the following (required):

1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)
3. Hepatitis B vaccine or testing documentation

Patient Name

DOB

Height

Weight

Allergies

Patient Phone

Diagnosis

- Rheumatoid Arthritis _____
- Other (ICD-10 Code): _____

Prescription Orders: Rituxan® (rituximab)) (quantity: 500 mg per vial)

Infuse _____mg over 5 hours on Day 1 and over 4.5 hours on day 15.

Start date: _____ ****Date of last Rituxan** _____

Pre-Medications:

- Acetaminophen 650mg PO Benadryl 25mg IVP Solu-Medrol 40 mg IVP
- Other _____

Standing Lab Orders: CMP CBC ESR CRP Other: _____ every infusion

Refills: 12 months _____ infusions

Physician Name

Phone

Fax

Physician's signature

Date

Fax completed form to (214) 887-0436. Contact us directly at: (214) 276-5642.

Or visit us online at www.ntinfusioncenters.com