

Intravene - Rituxan Infusion Orders (rev 10/2018)

Please fax this form along with a copy of insurance cards to:

Fax (434) 455-5531 or Call (434) 947-3900 ext. 2172

PATIENT INFORMATION

Name _____
Address _____
City _____
State _____ Zip code _____
Home Phone # _____
Work Phone # _____
DOB _____ SSN _____ Sex _____
Height _____ Weight _____
Allergies _____
Primary Insurance _____
Secondary Insurance _____

REFERRING PHYSICIAN INFORMATION

Physician Name _____
Physician Address _____

Physician Phone _____
Physician Fax _____
NPI# _____ DEA # _____
State License# _____

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DIAGNOSIS (ICD-10 required)

Has patient received a course of therapy in the past? yes no If yes, how many courses of therapy? _____

 _____ ↑ _____

PRE TREATMENT SCREENING:

Tuberculosis Screening: Date/Results of TB test _____

Hepatitis B Screening: Date/ Results: _____

Hepatitis C Screening: Date/Results: _____

PRIOR MEDICATIONS TRIED AND FAILED :

Is your patient currently taking or failed any of the following RA products?

Methotrexate--- Currently Taking Failed Date Failed _____

Leflunamide--- Currently Taking Failed Date Failed _____

Sulfasalazine--- Currently Taking Failed Date Failed _____

Humira----- Currently Taking Failed Date Failed _____

Prednisone----- Currently Taking Failed Date Failed _____

Remicade----- Currently Taking Failed Date Failed _____

Orencia----- Currently Taking Failed Date Failed _____

Enbrel----- Currently Taking Failed Date Failed _____

Other _____ Currently Taking Failed Date Failed _____

STANDARD ORDERS

Infuse Rituxan 1000mg in NS 250ml on Day 1 and Day 15. Infuse per Intravene protocol. Titrate per manufacturer's recommendation. Upon completion of Rituxan infusion, infuse Normal Saline 20ml.

Premedications:

Methylprednisolone 125mg IV 30 minutes prior to infusion.

Diphenhydramine 25mg -50mg PO or IV 30 minutes prior to infusion.

Acetaminophen 650mg PO 30 minutes prior to infusion.

Anaphylactic Medications and Vital Signs Monitoring per Intravene Protocol

DISCHARGE FROM INTRAVENE SERVICES WHEN INFUSION COMPLETED.

Signature, prescribing MD _____ Date _____