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. 3001

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#_____

** ***Please fax copy of insurance cards*** ***and this form to (434)- 455-5531***

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 _____