# Outpatient Infusion Center
# Rituxan Order

**Please fax form to: 580-585-5472**

## Patient Information

Patient Name: DOB: Phone: Gender M F

Patient Address: Email: Insurance:

## Additional Information Needed

- Fax front/back of insurance card
- Fax clinical/progress notes
- Fax labs
- Fax patient demographics
- Fax current medication list
- Fax TB and Hep B results

## Diagnosis and Clinical Information

**Diagnosis (ICD-10):**

- C85.90 Non- Hodgkin Lymphoma, Unspecified, Unspecified Site
- C91.0 Acute Lymphoblastic Leukemia (ALL)
- C91.1 Chronic Lymphocytic Leukemia of B-Cell Type
- G70.00 Myasthenia Gravis (gMG) without Acute Exacerbation
- L10.0 Pemphigus Vulgaris
- M05.89 Other Rheumatoid Arthritis with Rheumatoid Factor of Multiple Sites
- M06.09 Rheumatoid Arthritis without Rheumatoid Factor, Multiple Sites
- M06.89 Other Specified Rheumatoid Arthritis, Multiple Sites
- M06.9 Rheumatoid Arthritis, Unspecified
- M31.30 Wegener's Granulomatosis without Renal Involvement
- M31.31 Wegener's Granulomatosis with Renal Involvement
- M31.7 Microscopic Polyangitis

Other DX: ____________________

**Clinical Information:**

New Therapy Induction Therapy Change Therapy Continuation

Patient Weight: __________ lbs/__________ kg Patient Height: ________ in/ __________ cm

Allergies: ____________________

Therapies Tried and Failed: ____________________

TB Test: Date: __________ Results: __________ Hep B Test: Date: __________ Results: __________

Does the patient have venous access? Yes No If yes, What type? __________

If no, Initiate IV access

## Lab Orders

CBC CMP ESR CRP HBsAg HBsAB HBcAB

Quantiferon Gold

Other: ____________________

## Lab Orders to be done by

- Infusion Services
- Referring Provider

## Pre-Medications

Benadryl _____ mg PO IVP once 30 min prior to infusion

Acetaminophen _____ mg PO IVPB once 30 min prior to infusion

Methylprednisolone _____ mg PO IVP once 30 min prior to infusion

## Prescription Information

Rituxan

Dose and Frequency: 1000 mg days 0 and 14; then repeat course every _____ weeks (not sooner than every 16 weeks)

Dose and Frequency: 375mg/m² every week for _____ weeks

Dose and Frequency: _____ mg/m² every __________ for __________

Dose and Frequency: _____ mg every __________ for __________

Dose and Frequency: Other __________

## Misc Orders

PICC/ Midline/ CAD dressing to be changed every 7 days.

____________________

____________________

## Flushes

- 10mL NS Flush Syringe PRN
- Heparin 500units/5mL Flush Syringe PRN
- 50ml NS Bag PRN
- 250ml NS Bag PRN

## Standing Orders for Adverse Reactions

- Stop infusion and initiate NS bolus
- Notify Supervising physician and ordering provider
- Solu-Cortef 100mg SIVP signs of adverse reaction
- Benadryl 25mg SIVP for hives or bronchial inflammation
- Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
- Oxygen 2-5L nasal cannula
- Albuterol 2.5mg inhaled PRN for chest tightness
- Other: __________

## Prescriber Information

Physician Name: __________ Office Contact Name: __________

Contact #: __________ Fax Number: __________

Address: __________ City/State/Zip: __________

NPI#: __________ DEA#: __________ State License #: __________

____________________ ____________________

Physician's Signature Date Time