

Specialty Infusion Apothecary & Wellness Spa

INFUSION ORDERS- RITUXAN (RITUXIMAB)

PATIENT INFORMATION				
Name:		DOB:	DOB:	
Allergies: Date of Referral:				
REFERRAL STATUS				
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal				
DIAGNOSIS AND ICD 10 CODE				
☐ Rheumatoid Arthritis (RA	<u>\(\) \</u>	ICD1	ICD10: M06.9	
☐ Chronic Lymphocytic Let	ıkemia (CLL)	ICD10: C91.10		
☐ Other Diagnosis: ICD10:				
		QUIRED		
DOCUMENTATION				
• • •		inical/Progress notes supporting primary diagnosis		
		Labs and Tests supporting primary diagnosis		
information	☐ Hepatitis	☐ Hepatitis B Test Results: HBsAg & Total HepB Core Antibody		
MEDICATION ORDERS**				
Dosing Rituxan 1000mg IV every 14 days for two doses ONLY				
	☐ Rituxan 1000mg IV every 14 days for two doses; Repeat every 6 months			
☐ Rituxan 1000mg IV once				
☐ Rituxan 375 mg/m² IV every ☐ Other: Rituxan				
Refills:	$X ext{ 6 months} \qquad \Box X ext{ 1 year}$	□ dose	S	
PREMEDICATIONS				
☐ Acetaminophen 650mg PO, 30-60 minutes prior to rituximab infusion				
☐ Diphenhydramine 25mg PO, 30-60 minutes prior to rituximab infusion				
☐ Methylprednisolone 100mg Slow IV Push, 30 minutes prior to				
infusion □ Other:				
PRESCRIBER INFORMATION				
Prescriber Name:			0.00	
			Office	
Office Phone:	Office Fax:		Email:	

Contact us with questions at: info@siainfusions.com or call (561) 955-7079

Fax completed form and all documentation to (561) 617-5360

All information contained in this form is strictly confidential and will become part of the patient's medical record.