



# 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, every \_\_\_\_\_ months.

**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 or  \_\_\_\_\_ infusions

\_\_\_\_\_  
**Physician Name**

\_\_\_\_\_  
**Phone**

\_\_\_\_\_  
**Fax**

\_\_\_\_\_  
**Physician's signature**

\_\_\_\_\_  
**Date**

**Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.**

**For any other questions please call (469) 480-9649.**

**Or visit us online at [www.ntinfusioncenters.com](http://www.ntinfusioncenters.com)**