



RITUXAN

(rituximab)

PATIENT DEMOGRAPHICS

Patient Name: _____
Date of Birth: _____ M: ☐ F: ☐ Address: _____
Phone: _____ City, State, Zip: _____
Email: _____
Allergies: _____

PRIMARY DIAGNOSIS

ICD-10 Code: _____

DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

- ☐ Hepatitis B screening (HBsAg and anti-HBc) prior to therapy initiation required
- ☐ Baseline labs: CBC W/ differentials, AST, ALT, SCR
- ☐ Monitor serum creatinine and urine output periodically during therapy

Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

PRE-MEDICATION

- | | |
|--|---|
| <input type="checkbox"/> Acetaminophen 1000mg PO | <input type="checkbox"/> Solu-Medrol 125mg IVP |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Solu-Cortef 100mg IVP |
| <input type="checkbox"/> Ceterizine 10mg PO | <input type="checkbox"/> Diphenhydramine 25mg IVP |
| <input type="checkbox"/> Loratadine 10mg PO | <input type="checkbox"/> Other: _____ |

PRIMARY MEDICATION ORDER

Dosage

- ☐ 1000 mg
- ☐ 375mg/m2

Patient Weight:

_____ lbs
_____ kg

Frequency

- ☐ initial dose (0) followed by 2nd dose on day 15 (induction for RA diagnosis)
- ☐ single dose
- ☐ every week for 4 weeks total
- ☐ other frequency: _____

NOTES

ORDERING PROVIDER

Provider Name: _____	NPI: _____
Practice Name: _____	Phone: _____
Office Contact: _____	Fax: _____
Practice Address: _____	
City, State, Zip: _____	

Provider Signature: _____ Date: _____