

RITUXAN (rituximab – truxima – ruxience) Infusion Orders

Patient Name: _____ DOB: _____ ☐ M ☐ F

☐ NKDA Allergies: _____

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider: _____ Provider NPI: _____

Practice Phone: _____ Practice Fax: _____

Diagnosis *(please provide ICD-10 code):*

☐ _____ Rheumatoid Arthritis (RA) ☐ _____ *(other)*

Recommended Pre-Medication:

Acetaminophen ☐ 650mg PO / ☐ 1000mg PO
Diphenhydramine ☐ 25mg ☐ 50mg ☐ PO / ☐ IV
Solu-Medrol ☐ 125mg IVP ☐ Other: _____
☐ Other: _____

Required Documents:

☒ Patient Demographic Sheet
☒ Clinical/Progress notes, labs, tests supporting primary diagnosis *(please attach)*
☒ HepB Status & Date *(please attach results)*

MEDICATION ORDERS:

☐ Rituxan ☐ Rituximab ☐ Ruxience ☐ Truxima **Based on product availability and patient insurance requirement, product recommendations may be provided*

Dosing: ☐ 1000mg ☐ Other: _____

Mix in: ☐ 500ml 0.9% sodium chloride ☐ 250ml 0.9% sodium chloride

Frequency: ☐ Series: initial dose (day 0) follow by 2nd dose on day 15 *(induction for RA diagnosis)*
☐ Repeat series every 24 weeks
☐ Other: _____

Refills: _____ *(if not indicated, Rx will expire one year from date signed)*

Red River Health Standing Orders:

☒ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: _____ Date: _____