vitalcare INFUSION SERVICES of SIOUX FALLS

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RITUXAN (RITUXIMAB)
INFUSION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ Required Labs: CBC, Hep B panel (HBsAg anti-HBc)
☐ **Strongly recommended labs:** Quantitative Immunoglobulin (IgM, IgG and IgA): negative PPD or TB Gold; Anti-HCV antibody. Infusion will not be held if strongly recommended labs are not available.
☐ **Clinical/Progress Notes, Labs, Tests** supporting primary diagnosis (ICD-10 below)

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

J Code: J9310

RITUXAN ORDERS

Hepatitis B Protocol: Hep B surface antigen and Hep B Core AB total required.

*Date of last ☐ Remicade ☐ Orencia ☐ Humira ☐ Enbrel dose_____ ☐ Date:_____

Diagnosis: ☐ Rheumatoid Arthritis (ICD-10: _____)

☐ Other:_____ ☐ (ICD-10: _____)

OPTION 1: **Rituxan dose:** ☐ 1000mg on day 1 and day 15 after initial treatment
Frequency: ☐ One time dose only ☐ Every 24 weeks

(OR)

Diagnosis: ☐ Granulomatosis with Polyangiitis (ICD-10: _____)

☐ Microscopic Polyangiitis (ICD-10: _____)

OPTION 2: **Rituxan dose:** ☐ 375mg/M^2
Frequency: ☐ Weekly x 4 weeks ☐ Other:_____

For severe vasculitis symptoms:

☐ Solu-Medrol 1000mg IV daily for _____ days (1-3 days) within 14 days prior to Rituxan infusion.
☐ Solu-Medrol infuision to be followed by oral prednisone taper of lmg/kg/daily (not to exceed 80mg daily)
☐ Prednisone Rx provided by prescribing provider

Protocol Pre-medication Orders: ☐ Tylenol l000mg PO **and** Benadryl 50mg PO/IVP

☐ Solu-Medrol l00mg IVP ☐ Other:_____

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	