(rituximab)

RITUXAN infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Rheumatoid Arthritis
- ☐ _____ Granulomatosis w/Polyangitis *(wegener's granulomatosis GPA)*
- ☐ _____ Microscopic Polyangitis
- ☐ _____ _____ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____

RITUXAN ORDERS

DOSAGE

- ○ 1000mg
- ○ 375mg/m^2

PATIENT WEIGHT

_____ lbs.

_____ kg

FREQUENCY

- ○ intial 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

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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