

Rituxan

(rituximab)

Infusion Order



- 249 Danbury Rd. Wilton, CT 06897
- 400 Columbus Ave, Valhalla, NY 10595
- 127 Washington Ave, North Haven, CT 06473
- 220 Farmington Ave, Farmington, CT 06032
- _____

Ph: 203-883-0038 Fax: 203-724-4838

Patient Name: _____

DOB: _____

Phone: _____

Male Female

Allergies: _____

Diagnosis: _____

ICD- 10: _____

Please fax a copy of the following patient information:

- Recent progress Note Current CBC & CMP Hep B Results (*upon initiation*)

Hep B (HBsAg and anti- HBV) test date: ____/____/____ Result: _____

PRE- MEDICATIONS:

- Acetaminophen 1000mg PO Solu- Medrol 125mg IVP
 Diphenhydramine 25mg PO Solu- Cortef 100mg IVP
 Cetirizine 10mg PO Diphenhydramine 25mg IVP
 No Pre-med Other: _____

RITUXAN ORDER

DOSAGE

- 1000mg
 375mg/ m²

Patient Weight: _____ *lbs* _____ *kg*
Height: _____ *ft* _____ *in*

FREQUENCY

- On day 1 and day 15 every 6 months
 Once weekly for 4 weeks

Single dose
Other frequency: _____

NOTES:

Provider's Name: _____ Signature: _____

NPI: _____ Date: _____ Ph: _____ Fax: _____