Fax: 614-929-7199 | Phone: 614-929-3349| Email: info@infuseoneohio.com

INFUSE ONE

RITUXIMAB infusion orders

Patient Name _____ DOB _____

Phone Number _____ M ____ F _____

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Microscopic Polyangiitis ☐ _____ Rheumatoid Arthritis

☐ _____ Granulomatosis w/ Polyangiitis ☐ _____ Other

PRE-MEDICATIONS

☐ Acetaminophen 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ _____ (other)

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____ (other)

RITUXIMAB ORDERS

RITUXIMAB PRODUCT

☐ Rituxan

☐ Truxima

☐ Ruxience

DOSAGE

☐ 1000mg

☐ _____ Other

FREQUENCY

☐ initial dose (0) followed by 2nd dose on day 15 *(induction for RA diagnosis)*

☐ single dose

☐ every week for 4 weeks total

☐ _____ Other

Patient Weight

_____ lbs

_____ kg

- Please fax the patient's hepatitis B test results with this completed form

ORDERING PROVIDER

Signature _____ Phone_____Fax_____

Provider _____ Date _____