Infusion Associates
3230 Eagle Park NE, Suite 101
Grand Rapids, MI 49525
Phone: 616-954-0600 Fax: 616-954-1675

# Rituxan for Rheumatoid Arthritis Order
## (Rituximab)

***Please fax a copy of patient's Demographics, Insurance information, Current Lab Results, H&P, Current Medications, Letter of Medical Necessity and BIF***

**Date**: _____/_____/_____

**Patient Name**: _____ **DOB**: _____/_____/_____

**Allergies**: _____ **Patient Weight:** _____lbs / kg **Height:**_____

**DX CODES:** ***ICD-10*** **: _____, _____, _____**

**History of CHF / COPD** □No □ Yes if yes explain:_____

**Antihypertensive medications held for 12 hrs. prior to Rituxan infusion:** □Yes □ No
List medications to be held:_____

**LABS** to be drawn: □ **CBC** □ Other: _____

| | | | |
|---|---|---|---|
| **Pre- Medications**: | **Diphenhydramine PO/IV** | 25mg or 50 mg | □Yes □ No |
| | **Acetaminophen PO** | 650mg | □Yes □ No |
| | **Solu-Medrol IV** | _____mg | □Yes □ No |

## Rituxan IV Dosage:

**1000mg /NS 0.9% 1000ml (Conc. 1mg/ml) □ Other: _____**

**Start Date of Infusion**: _____/_____/_____ **Rituxan Infusion # _____**

**Frequency:** Infusions given at Day 1 and Day 15 then repeat in 6 months for a total of 4 doses a year unless otherwise specified:_____

Infuse per the Infusion Associates Rituxan infusion protocol.

**Printed Provider's Name**: _____

**Provider Signature**: _____

**Office Phone Number: _____Office Fax Number: _____**