



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, and Current Medications*

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	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Acetaminophen PO	650mg	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Solu-Medrol IV	_____mg	<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____