NORTH TEXAS INFUSION CENTERS

Rituxan® (rituximab) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)
3. Hepatitis B vaccine or testing documentation

_____ _____
Patient Name **DOB**

_____ _____ _____ _____
Height **Weight** **Allergies** **Patient Phone**

Diagnosis
☐ Rheumatoid Arthritis _____
☐ Other (ICD-10 Code): _____

Prescription Orders: Rituxan® (rituximab)) (quantity: 500 mg per vial)

Infuse _____ mg over 5 hours on Day 1 and over 4.5 hours on day 15, every ____ months.

Start date: _____ Date of last Rituxan _____**

Pre-Medications:
☐ Acetaminophen 650mg PO ☐ Benadryl 25mg IVP ☐ Solu-Medrol 40 mg IVP
☐ Benadryl 50mg IVP ☐ Solu-Medrol 125mg IVP
Other _____

Standing Lab Orders: ☐ CMP ☐ CBC ☐ ESR ☐ CRP ☐ Other: _____
☐ every infusion or ☐ Day 1 infusion only

Refills: ☐ 12 months or ☐ for _____ infusions

_____
Provider Name **Phone** **Fax**

_____
Provider's signature **Date**

Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com