

Ruxience® (rituximab-pvvr) 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: Ruxience® (rituximab-pvvr) (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 Ruxience** _____

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