Rose Pharmacy 10008 Pines Blvd Pembroke Pines, FL 33024 Phone: 888.797.4632 / 954.432.8290 Fax: 844.246.3364



INFUSION ORDERS- RITUXAN (RITUXIMAB)

PATIENT INFORMATION				
Name:		DOB:	DOB:	
Allergies:		Date of Referral:	Date of Referral:	
REFERRAL STATUS				
☐ New Referral ☐ Dose or Frequency Change ☐ Order R			☐ Order Renewal	
DIAGNOSIS AND ICD 10 CODE				
☐ Rheumatoid Arthritis (RA)		ICD10: M06.9		
☐ Chronic Lymphocytic Leukemia (CLL)		ICD10: C91.10		
☐ Other Diagnosis:		ICD10:		
REQUIRED				
DOCUMENTATION				
☐ This signed order form by the provider		☐ Clinical/Progress notes supporting primary diagnosis		
☐ Patient demographics AND insurance		☐ Labs and Tests supporting primary diagnosis		
information		☐ Hepatitis B Test Results: HBsAg & Total HepB Core Antibody		
MEDICATION ORDERS**				
Dosing ☐ Rituxan 1000mg IV every 14 days for two doses ONLY			es ONLY	
	☐ Rituxan 1000mg IV every 14 days for two doses; Repeat every 6 months			
	☐ Rituxan 1000mg IV once			
	☐ Rituxan 375 mg/m² IV every			
		tuxan		
Refills:	X 6 months	□ X 1 year □ Doses		
remis.	71 0 months			
PREMEDICATIONS				
☐ Acetaminophen 650mg PO, 30-60 minutes prior to rituximab infusion				
☐ Diphenhydramine 25mg PO, 30-60 minutes prior to rituximab infusion				
☐ Methylprednisolone 100mg Slow IV Push, 30 minutes prior to infusion				
□ Other:				
PRESCRIBER INFORMATION				
Prescriber Name:				
			Office:	
Office Phone: Office Fax:			Email:	
Prescriber Signature:			Date:	

Contact us with questions at: info@rosenursing.net or call **887.797.4632** / **954.432.8290**