Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226

INFUSION SOLUTIONS

Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Rituxan (Rituximab)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:

REFERRAL STATUS
☐ New Referral ☐ Dose/Frequency Change ☐ Order Renewal

Location Preference (optional)
☐ Richmond ☐ Prince George

If patient has a central line, then the placement report, diagnostic imaging to confirm tip placement and date of last access are required

DIAGNOSIS AND ICD-10 CODE *	
☐ Pemphigus Vulgaris	L10.0
☐ Wegener's Granulomatosis	M31.30
☐ Other: _____	ICD10 _____

*Medication is approved for MULTIPLE diagnoses. If prescriber would like a custom order form, please reach out to Infusion Solutions.

REQUIRED DOCUMENTATION (must include)	
☐ This signed order form by the provider	☐ Clinical/Progress Notes
☐ Patient Demographics AND Insurance Information	☐ Labs and Tests Supporting Primary Dx
☐ HBV Panel results	☐ CBC w/Platelets
☐ Documentation of Concomitant Corticosteroid therapy (for Pemphigus Vulgaris or Wegener's diagnosis)	
☐ Patient currently receiving same therapy at _____ Last dose: _____	
List Tried & Failed Therapies, including duration of treatment	
1)	3)
2)	4)

MEDICATION ORDERS	
Initial Dosing for Pemphigus Vulgaris	☐ Rituxan 1000mg infuse IV over 4-6 hours on days 1 and 15, then 500mg every ____ weeks
Induction Dosing for Wegener's	☐ Rituxan 375mg/m(2)** IV once weekly for 4 weeks***
Maintenance Dosing for Wegener's	☐ Rituxan 500mg IV once every 6 months
***Height and Weight required to calculate BSA.*	
****IF subsequent induction doses are indicated, then contact Infusion Solutions.*	
Alternative Dosing	☐ Rituxan ____ mg infuse over 4-6 hours every _____
Patient Weight: _____ kg or _____ lb	Patient Height: _____ in BSA:_____
Duration: ☐ x 6 months ☐ x 1 year ☐ doses _____	

REQUIRED PREMEDICATIONS and OPTIONAL ADDITIONAL PREMEDS and LAB ORDERS
☒ REQUIRED : Acetaminophen 650mg PO prior to infusion
☒ REQUIRED: Diphenhydramine 25mg PO or IV (per patient preference) prior to infusion
☒ REQUIRED: Methylprednisolone 100mg slow IVP prior to infusion
☐ OPTIONAL: CBC and CMP every 6 months
☐ Other PreMed or Lab Order with frequency: _____

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:		Date:

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com

Fax completed form and ALL required documentation to 804-554-5848

All information contained in this form is strictly confidential and will become part of the patient's record.