vitalcare of CENTRAL MISSISSIPPI

Fountains Infusion Center

159 Fountains Blvd. Madison, MS 39110
Phone: 601.859.8200 Fax: 601.859.8201

RITUXIMAB
INFUSION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ Required Labs: CBC, Hep B panel (HBsAg anti-HBc)
☐ **Strongly recommended labs:** Quantitative Immunoglobulin (IgM, IgG and IgA): negative PPD or TB Gold; Anti-HCV antibody. Infusion will not be held if strongly recommended labs are not available.
☐ **Clinical/Progress Notes, Labs, Tests** supporting primary diagnosis (ICD-10 below)

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis: ☐ Rheumatoid Arthritis ☐ Granulomatosis w/ Polyangiitis ☐ Microscopic Polyangiitis ☐ Pemphigus Vulgaris
ICD-10: _____ ☐ Other: _____

RITUXIMAB ORDERS

Rituximab: (choose one)
☐ Infuse Rituximab OR Rituximab biosimilar as required by patient's insurance (Rituxan, Ruxience,Truxima)
☐ Do not substitute. Infuse the following Rituximab product: _____

*Date of last Rituximab infusion:_____

Dose: ☐ 1000mg ☐ 375mg/m2 ☐ 500mg ☐ Other: _____ **Refills**_____

Frequency: ☐ Day 1 and Day 15 ☐ Every 24 weeks
☐ One time dose
☐ Other: _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

Lab orders: _____ **Frequency:** _____

Protocol Pre-medication Orders: ☐ Tylenol 650mg PO **and** Benadryl 50mg PO/IVP **and** Solu-Medrol l00mg IVP
☐ Other:_____

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	