eMediateINFUSIONcenter

RITUXAN(rituximab)

☐ New Prescription/Referral
☐ Prescription Refill

# of Refills:

Rx:

Patient Name:

DOB:

RITUXAN:

- ☐ Administer as two 1000mg IV infusions separated by 2 weeks
- ☐ Administer as two 500mg IV infusions separated by 2 weeks
- ☐ Repeat after 6 months.
- ☐ Initial Infusion: 50mg/hr, increase rate by 50mg/hr every 30 mins until max infusion rate of 400mg/hr
- ☐ Subsequent Infusions: 100mg/hr, increase rate by 100mg/hr every 30 mins until max infusion rate of 400mg/hr

Other Orders:

Pre-Medication: (30 mins prior)

- ☐ Solumedrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Others:
- ☐ Tylenol _____mg PO
  - ☐ 650mg ☐ 975mg
- ☐ Benadryl _____mg
  - ☐ 25mg ☐ IV
  - ☐ 50mg ☐ PO

ANA Kit Protocol:

- ☐ OK to use

Dx:

- ☐ Rheumatoid Arthritis (M05.79)
- ☐ Others:

N P I #:

Physician Signature

Date: (Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name:

CLINIC:

Contact Information:

Phone:

Email:

Fax:

Other:

Office Mailing Address:

Please include the following

- ☐ Patient demographics
- ☐ Insurance attached
- ☐ Diagnosis (supporting)
- ☐ History and Physical
- ☐ Lab Results
- ☐ Clinical progress notes
- ☐ Medication List
- ☐ Other Test Results

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