Fax: 561-516-6626 | Email: Info@infuseone.com | Phone: 561-337-4055

INFUSE ONE

(rituximab)

RITUXAN infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Rheumatoid Arthritis

☐ _____ Granulomatosis w/Polyangiitis
(wegener's granulomatosis GPA)

☐ _____ Microscopic Polyangiitis

☐ _____ _____
(other)

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ _____

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____

RITUXAN ORDERS

DOSAGE

○ 1000mg

○ 375mg/m^2

PATIENT WEIGHT

_____ lbs.

_____ kg

FREQUENCY

○ intial dose (0) followed by 2nd dose on day 15 *(induction for RA diagnosis)*

○ single dose

○ every week for 4 weeks total

○ _____
(other frequency)

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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