

one

## Rituximab (Rituxan, Truxima, Ruxience) Infusion Orders

Patient Name:	DOB:	☐ Male ☐ Female
Diagnosis (please provide ICD10 code)		
□ Other:		
□ NKDA Allergies:		
□ New Start Therapy □ Continuation of Therapy	Date of last dose (if app	licable):
Ordering Provider:		
Provider NPI:	Phone:	Fax:
Practice Address:	City:	State: Zip Code:
RECOMMENDED PRE-MEDICATION	REQUII	RED LABS
Acetaminophen	/ primary	/Progress Notes, Labs, Tests supporting / diagnosis (please attach)  is B status & date (please attach results):
RITUXIMAB ORDERS		
	uirements, product reco	ty and patient insurance nmendations may be provided
Mix in: $\square$ 500ml 0.9% sodium chloride OR	☐ 250ml 0.9% s	odium chloride
Administer Intravenous Infusion per Infuse One Rituxii	mab Protocol	REFILLS:
FREQUENCY:		
☐ On Series Day 0 and Series Day 14 ☐ Repeat series ☐ Other:	every 24 weeks	(if not indicated order will expire year from date signed)
Infuse One Standing Orders:  Provide treatment under Infuse One's Clinical Guidelines, Medicand Action Plan for Infusion Reactions.	cation Safety Protocol, Em	ergency Guidelines,
Provider Signature		

Pre-medicate patients with an antihistamine and acetaminophen prior to dosing. For RA and PV patients, methylprednisolone intravenously or its equivalent is recommended 30 minutes prior to each infusion.

Screen all patients for HBV infection by measuring HBsAg and anti-HBc before initiating treatment with Rituxan. For patients who show evidence of prior hepatitis B infection (HBsAg positive [regardless of antibody status] or HBsAg negative but anti-HBc positive), consult with physicians with expertise in managing hepatitis B regarding monitoring and consideration for HBV antiviral therapy before and/or during RITUXAN treatment.