(rituximab)

RITUXAN infusion orders

Evansville Multi-Specialty Clinic

Patient Name _____ DOB _____

Phone _____ M ☐ F ☐

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Rheumatoid Arthritis

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

☐ _____ Microscopic Polyangitis

☐ _____ _____
(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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