Mankato Clinic
Together we thrive.

ADULT AMBULATORY INFUSION ORDER
Rituximab (RITUXAN)
Rituximab-pvvr (RUXIENCE)

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Date: _____/_____/_____

*__Please fax a copy of the following patient information__: ☐ Demographics ☐ Insurance Information ☐ Current Lab Results ☐ H & P Relevant to Diagnosis ☐ Last infusion note ☐ Current Medications

PATIENT INFORMATION

Allergies: _____

Weight: _____ lbs/kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ____/____/_____

Phone: (____)_____-_____ Fax: (____)____-_____

Office Address: _____

Contact Person: _____

TB Test Date: ____/_____/____ Result: _____ ☐ Copy Attached

Hep B Date: ____/_____/_____ Result: _____ ☐ Copy Attached

PRE-MEDICATIONS:

Diphenhydramine: ☐ IV ☐ 50mg

Acetaminophen: ☐ PO ☐ 650 mg ☐ 1000 mg

Solu-Medrol: ☐ IV ☐ _____ mg

Other: ☐ _____

☐ 30 minute wait time following pre-medications

LABS:

☐ CBC w/diff ☐ EVERY infusion ☐ every OTHER infusion ☐ other: _____

☐ CMP ☐ EVERY infusion ☐ every OTHER infusion ☐ other: _____

☐ CRP ☐ EVERY infusion ☐ every OTHER infusion ☐ other: _____

☐ Other: _____ ☐ EVERY infusion ☐ every OTHER infusion ☐ other: _____

☐ No labs needed

Please check preferred product:

☐ **RITUXAN (rituximab) IV Dosing**

☐ **RUXIENCE (rituximab-pvvr) IV Dosing**

Dose: _____ **Frequency**: _____

Start Date of Infusion: ____/____/____