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| ADULT AMBULATORY INFUSION ORDER  **Rituximab (RITUXAN)**  **Rituximab-pvvr (RUXIENCE)** | **NAME:**  **BIRTHDATE:**    *Affix Patient Identification Label Here* |
| **ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (**  **) TO BE ACTIVE.** | |

**Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**

Patient Information

Provider Information

\***Please fax a copy of the following** □Demographics □ Insurance Information □ Current Lab Results **patient information**: □ H & P Relevant to Diagnosis □ Last infusion note □ Current Medications

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight: \_\_\_\_\_\_\_\_\_\_\_\_ lbs/kg Height: \_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

ICD-10: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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

MC2684 (04/22)

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: \_\_\_\_/\_\_\_\_/\_\_\_\_