



Physician-led - Patient-centered - Infusion-care

Please fax completed form, insurance card, and clinical documentation to:  
**FAX: 410-220-2553**

### RITUXIMAB ORDER NEPHROLOGY

New Start  Maintenance: Last Dose Given \_\_\_\_\_

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:		Fax:
Patient Name:		DOB:

Allergies  NKDA  Allergies:

\_\_\_\_\_ Height: \_\_\_\_\_

\_\_\_\_\_ Weight: \_\_\_\_\_

**Indication:**

I77.8 ANCA positive vasculitis

N04. Nephrotic Syndrome

N05. Focal Segmental glomerulonephritis

Other \_\_\_\_\_

**DRUG:** Rituxan | Truxima | Riabni | Ruxience

Rituximab-per insurance preferred

Rituxan

Truxima (rituximab-abbs)

Riabni (rituximab-arrx)

Ruxience (rituximab-pvvr)

<p><b>INDUCTION DOSES:</b></p> <p><input type="checkbox"/> 375mg/m2 every week X 4 weeks</p> <p><input type="checkbox"/> 1000mg IV at day 0 and 15 (approximately) <input type="checkbox"/> Other _____</p> <p>_____</p>	<p><b>MAINTENANCE DOSES:</b></p> <p><input type="checkbox"/> 500mg IV at day 0 and 15 (approximately) <input type="checkbox"/> 500mg IV every _____</p> <p><input type="checkbox"/> Other _____</p>
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**PREMEDICATION ORDERS:** *antihistamine, acetaminophen and 100mg methylprednisolone are recommended in*

*the PI*  Acetaminophen po:  1000mg  500mg 30 min prior to infusion.

Diphenhydramine:  25mg PO  50mg PO  25mg IVP 30 min prior to infusion.

Solu-Medrol:  62.5mg IVP  100mg IVP  Other \_\_\_\_\_ 30 min prior to infusion.

Other \_\_\_\_\_

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

**Referrals will not be processed until we receive ALL the following:**

Face Sheet / Patient Demographics

Insurance card(s) – copy of front & back

Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:

CBC  CMP  TB  Hep B Other: \_\_\_\_\_