



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>INDUCTION DOSES:</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>MAINTENANCE DOSES:</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>
---	---

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: _____