RED RIVER HEALTH
Ambulatory Infusion Clinic

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RITUXAN (rituximab – truxima – ruxience) Infusion Orders

Patient Name: DOB: ☐ M ☐ F

☐ NKDA Allergies:

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable):

Ordering Provider: Provider NPI:

Practice Phone: Practice Fax:

Diagnosis *(please provide ICD-10 code)*:

☐ _____ Rheumatoid Arthritis (RA)

☐ _____ _____ *(other)*

Recommended Pre-Medication:

Acetaminophen ☐ 650mg PO / ☐ 1000mg PO
Diphenhydramine ☐ 25mg ☐ 50mg ☐ PO / ☐ IV
Solu-Medrol ☐ 125mg IVP ☐ Other: _____

☐ Other: _____

Required Documents:

☑ Patient Demographic Sheet

☑ Clinical/Progress notes, labs, tests supporting primary diagnosis *(please attach)*

☑ HepB Status & Date *(please attach results)*

☑ Recent CBC w/ diff (please attach)
If unavailable, will collect at first infusion appt

MEDICATION ORDERS:

☐ Rituxan ☐ Rituximab ☐ Ruxience ☐ Truxima **Based on product availability and patient insurance requirement, product recommendations may be provided*

Dosing: ☐ 1000mg ☐ Other: _____

Mix in: ☐ 500ml 0.9% sodium chloride ☐ 250ml 0.9% sodium chloride

Frequency: ☐ Series: initial dose (day 0) follow by 2nd dose on day 15 *(induction for RA diagnosis)*

☐ Repeat series every 24 weeks

☐ Other: _____

Refills: _____ *(if not indicated, Rx will expire one year from date signed)*

Red River Health Standing Orders:

☑ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: Date: