Infusion ASSOCIATES

Phone: 616-954-0600 Fax: 616-954-1675

Rituximab IV Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10 : _____, _____, _____

In the past year, what medications for the above diagnosis has the patient tried and failed?
☐ N/A continuation of treatment

Drug	Dose	Dates of use

Hepatitis B Virus Screening is required before first dose: ☐ **COPY ATTACHED**
Result Date: _____/_____/_____ Result ***(circle one):*** **Positive** **Negative**

Labs to be collected: ☐CMP ☐CBC w/o diff ☐CBC w/diff ☐CBC w/man diff ☐ Other:_____
Lab Frequency: ☐ EVERY infusion ☐ Every OTHER infusion ☐ Other:_____

Pre-Medications:			
Diphenhydramine PO or IV	25mg or 50mg	☐Yes	☐ No
Acetaminophen PO	650mg	☐Yes	☐ No
Methylprednisolone IVPush	125mg	☐Yes	☐ No

☐ **Pharmacist to select product**

☐ **Rituxan (rituximab) IV**
☐ **Ruxience (rituximab-pvvr) IV**
☐ **Truxima (rituximab-abbs) IV**

Dose: ☐ _____mg

Frequency: _____

☐ **Continuation of treatment** **RX Expiration Date: _____/_____/_____**

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____Office Fax Number: _____