

**Richmond**  
7110 Forest Ave, Suite 203  
Richmond, VA 23226



**Prince George**  
2025 Waterside Rd, Suite 100B  
Prince George, VA 23875

**Physician Order - Rituxan (Rituximab)**

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose/Frequency Change <input type="checkbox"/> Order Renewal

Location Preference (optional)
<input type="checkbox"/> Richmond <input type="checkbox"/> Prince George

\*If patient has a central line, then the placement report, diagnostic imaging to confirm tip placement and date of last access are required\*

DIAGNOSIS AND ICD-10 CODE *	
<input type="checkbox"/> Pemphigus Vulgaris	L10.0
<input type="checkbox"/> Wegener's Granulomatosis	M31.30
<input type="checkbox"/> Other: _____	ICD10 _____

\*Medication is approved for MULTIPLE diagnoses. If prescriber would like a custom order form, please reach out to Infusion Solutions.

REQUIRED DOCUMENTATION (must include)	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress Notes
<input type="checkbox"/> Patient Demographics AND Insurance Information	<input type="checkbox"/> Labs and Tests Supporting Primary Dx
<input type="checkbox"/> HBV Panel results	<input type="checkbox"/> CBC w/Platelets
<input type="checkbox"/> Documentation of Concomitant Corticosteroid therapy (for Pemphigus Vulgaris or Wegener's diagnosis)	
<input type="checkbox"/> Patient currently receiving same therapy at _____	Last dose: _____
List Tried & Failed Therapies, including duration of treatment	
1) _____	3) _____
2) _____	4) _____

MEDICATION ORDERS	
Initial Dosing for Pemphigus Vulgaris	<input type="checkbox"/> Rituxan 1000mg infuse IV over 4-6 hours on days 1 and 15, then 500mg every _____ weeks
<b>Induction</b> Dosing for Wegener's	<input type="checkbox"/> Rituxan 375mg/m(2)** IV once weekly for 4 weeks***
<b>Maintenance</b> Dosing for Wegener's	<input type="checkbox"/> Rituxan 500mg IV once every 6 months
**Height and Weight required to calculate BSA.	
***IF subsequent induction doses are indicated, then contact Infusion Solutions.	
Alternative Dosing	<input type="checkbox"/> Rituxan _____ mg infuse over 4-6 hours every _____
Patient Weight: _____ kg or _____ lb	Patient Height: _____ in                      BSA: _____
Duration: <input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> doses _____	

REQUIRED PREMEDICATIONS and OPTIONAL ADDITIONAL PREMEDS and LAB ORDERS
<input checked="" type="checkbox"/> REQUIRED : Acetaminophen 650mg PO prior to infusion
<input checked="" type="checkbox"/> REQUIRED: Diphenhydramine 25mg PO or IV (per patient preference) prior to infusion
<input checked="" type="checkbox"/> REQUIRED: Methylprednisolone 100mg slow IVP prior to infusion
<input type="checkbox"/> OPTIONAL: CBC and CMP every 6 months
<input type="checkbox"/> Other PreMed or Lab Order with frequency: _____

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:	Date:	

Contact us with questions at: 804-442-3558 or email [referrals@theinfusionsolution.com](mailto:referrals@theinfusionsolution.com)

Fax completed form and ALL required documentation to 804-554-5848

All information contained in this form is strictly confidential and will become part of the patient's record.