smartinfusion THERAPY SERVICES

Phone and Fax: 608-690-7210
Email: info@MySmartInfusion.com
www.MySmartInfusion.com

Rituxan (Rituximab)

Infusion Order Form

Patient Information

Patient Name: _____DOB: _____ M ☐ F ☐

Allergies: _____

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

☐ Rheumatoid Arthritis ICD 10 Code: M06.9 ☐ Chronic Lymphocytic Leukemia ICD 10 Code: C91.10

☐ Other: _____ ICD 10 Code: _____

Required Tests (within 12 months & attach results)

TB/Quantiferon Status & Date: _____

Hepatitis B Status & Date: _____

Required Labs (within 3 months & attach results)

CBC Results _____

CMP Results _____

CRP Results _____

Other: _____

Pre-Medication Orders

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg ☐ PO

Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

Methylprednisolone (Solu-Medrol) ☐ 125mg ☐ IV

Ondansetron (Zofran) ☐ 4mg ☐ 8mg ☐ PO ☐ IV

Other: _____ Route: _____

Dose: _____ Frequency: _____

Nursing

Provide nursing care per Smart Infusion Nursing Procedures, Including reaction management and post-procedure observation.

Special Instructions / Notes

Rituxan Medication Order

Patient Weight: _____KG

Dosage

☐ 375mg IV ☐ 1000mg IV Other: _____

Frequency

☐ Induction week 0 and week 2 then repeat every 6 months

☐ Other _____

Required Documents

☐ Patient Demographic Sheet

☐ H & P within the past 6 months

☐ Current Medication List

☐ Clinical and Progress Notes

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____