

Truxima (Rituximab-abbs) Infusion Order

Patient Name: _____ DOB: _____ Male Female

Diagnosis (please provide ICD10 code): _____

Other: _____

NKDA Allergies: _____

New Therapy Order Continuation of Therapy Date of last dose: _____

Ordering Provider Name: _____

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Pre-Medication

- Acetaminophen _____mg by PO
- Cetirizine _____mg by PO
- Diphenhydramine _____mg by PO/ IVP
- Solu-Medrol _____mg by PO/ IVP
- Solu-Cortef _____mg by PO/ IVP
- Other: _____

Required Documentation:

- Patient Demographics
- Patient Insurance (med and pharm card copies, front and back)
- Progress Notes/Labs supporting diagnosis
- Hepatitis B Test Results: HBsAg and Total HepB Core Antibody
- Quantiferon lab results
- CD4/CD8
- Other: _____

Patient height and weight:

Patient Height (cm): _____ Patient Weight (kg): _____

Truxima Medication Order:

- IV Dosing (Please choose one)
 - 500mg
 - 1000mg
 - Other: _____
- Frequency (Please choose applicable)
 - 2 doses, 14 days apart
 - Repeat series every 24 weeks
 - Other: _____

Additional Instructions/Notes: _____ _____ _____	Patient IV Access <input type="checkbox"/> PIV <input type="checkbox"/> Use patient's SL/DL PICC, flush per protocol <input type="checkbox"/> Access/deaccess patient's Port, flush per protocol *Imaging results of proper placement required for PICC/Port
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Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____

Locations: <input type="checkbox"/> Skokie, IL: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141 <input type="checkbox"/> Libertyville, IL: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141 <input type="checkbox"/> Houston, TX: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400
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