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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 BTest Results: HBsAg and Total HepB Core Antibody
□ Quantiferon lab results
□ CBC/CMP
□ 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

□ PIV
□ Use patient's SL/DL PICC, flush per protocol
□ Access/deaccess patient's Port, flush per protocol
*Imaging results of proper placement required for PICC/Port

Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____

Locations:

□ *Skokie, IL*: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141
□ *Libertyville, IL*: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141
□ *Orland Park, IL*: 16612 107th Ct, Ste B. P: 847-324-6800. F: 224-251-7141
□ *Houston, TX*: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400