

Rituximab (Rituxan, Truxima, Ruxience) Infusion Orders

Patient Name: _____ DOB: _____ ☐ Male ☐ Female

Diagnosis (please provide ICD10 code) _____

☐ Other: _____

☐ NKDA Allergies: _____

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider:

Provider NPI: _____ Phone: _____ Fax: _____

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

PRE-MEDICATIONS

- ☐
- Acetaminophen 1000mg PO, Diphenhydramine 50mg IV, and Solu-Medrol 100mg IV

**Patient will receive above premeds per Sage Infusion Medication Safety Protocol unless different premeds are noted below*

☐ Other PreMeds: _____

REQUIRED LABS

- ☒
- Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (please attach)
-
- ☒
- Hepatitis B status & date (please attach results): _____

RITUXIMAB ORDERS

- ☐
- Rituxan
- ☐
- Truxima
- ☐
- Ruxience
- *Based on product availability and patient insurance requirements, product recommendations may be provided*

DOSING:

Dose: ☐ 1000 mg OR ☐ Other: _____ mg

Mix in: ☐ 500ml 0.9% sodium chloride OR ☐ 250ml 0.9% sodium chloride

- ☒
- Administer Intravenous Infusion per Sage Infusion Rituximab Protocol

FREQUENCY:

- ☐
- On Series Day 0 and Series Day 14
- ☐
- Repeat series every 24 weeks (Day 0, & Day 14)

☐ Other: _____

REFILLS:

☐ _____
(if not indicated order will expire one year from date signed)

☒ Sage Infusion Standing Orders:

Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name

Provider Signature

Date