

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: _____

RECOMMENDED PRE-MEDICATION

Acetaminophen 650mg PO / 1000mg PO
 Diphenhydramine 25mg 50mg PO / IV
 Solu-Medrol 125mg IVP Other: _____

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

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