

INFUSION ORDERS RITUXAN

Patient's Information

Date of Referral

First Name Last Name M.I.

Date of Birth

Address

City State ZIP Code

Phone

WT (kg) HT (in)

Diagnosis

Allergies

Please fax most recent TB and HEP B test date and results.

*ICD 10 CODE

*** Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval.**

RITUXAN DOSING

Administer mg by intravenous (IV) infusion once every months.

INFUSION REACTION ORDER, CHOOSE ONE:

- Pure's Infusion Reaction Protocol
- Attached Infusion Reaction Protocol

Prescribing Provider

Address

City State ZIP Code

Provider Signature Date/Time

Provider Phone Provider Fax