Rituximab (Rituxan)

Provider Order Form

Newport Superior Infusion
1501 Superior Ave, Suite 202
Newport Beach, CA 92663
Phone: 949-601-6001
Fax: 866-542-8631

PATIENT INFORMATION

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight lbs / kg: Height in / cm:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☐ Provide nursing care per Newport Infusion Standard Procedures

☐ Hepatitis B status and date (list results and attach clinicals): _____

RECOMMENDED PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ methylprednisolone (Solu-Medrol) 125mg IV

PRE-MEDICATION ORDERS

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ famotidine (Pepcid) 20mg PO

☐ Ondansetron ODT (Zofran) 4mg PO

☐ Other:_____

Dose: _____ Route: _____

Frequency: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Other: _____

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

☑ **Rituximab** (Rituxan) intravenous infusion

- Dose
  - ☐ 250mg/m2
  - ☐ 375mg/m2
  - ☐ 500mg/m2
  - ☐ 1000mg/m2
  - ☐ Other: _____
- Frequency
  - ☐ Administer once weekly for 4 doses
  - ☐ Administer once weekly for 8 doses
  - ☐ Administer on day 1 of each cycle of chemotherapy for up to 8 doses
  - ☐ Administer every 8 weeks for 12 doses
  - ☐ Administer once weekly for 4 doses at 6 month intervals for maximum of 16 doses
  - ☐ Administer every 24 weeks
  - ☐ Administer every 16 weeks
  - ☐ Administer 2 infusions 2 weeks apart
  - ☐ Other: _____
- Rate
  - ☐ Initiate first infusion at rate of 50mg/hr. If tolerated, increase infusion rate by 50mg/hr increments to max infusion rate of 400mg/hr
  - ☐ Initiate subsequent infusions at rate of 50mg/hr. If tolerated, increase infusion rate by 50mg/hr increments to max infusion rate of 400mg/hr

Refills: ☐ Zero / ☐ for 12

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

Provider Name (Print) **Date**

Provider Signature