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Troy, OH 45373
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Washington Township Infusion Center
1989 Miamisburg-Centerville Road
Suite 101
Dayton, OH, 45459
Phone: 937-401-6620
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Rituximab Order Form

Epic Referral: REF115206

Patient Name: ____ **DOB:** _______________________

Address: ____

Phone: _______________________________________

ICD-10 Diagnosis: ______________ *****Please see attached list for approved diagnosis codes*****

Rx:

☐ Rituximab 1000mg IV every 14 days x 2 treatments

☐ Repeat above course every 6 months x 1 year

> Truxima (rituximab-abbs)
> *If patient is receiving for rheumatoid arthritis, biosimilar Truxima will be used for patient cost savings per Kettering Health formulary.*

OR

☐ Rituximab 375mg/m^2 IV ☐ weekly ☐ every 2 weeks ☐other frequency: _______________

Total number of treatments: __________________

Pre-meds: (given at each rituximab infusion)

☐ Solumedrol 100 mg IV or ☐ Solumedrol _____ mg IV

☐ Tylenol 1000 mg po or ☐Tylenol 650 mg po

☐ Benadryl ____ mg po or ☐ Benadryl _____ mg IV

☐ Famotidine 20mg po

☐ Other: ____

> *Solumedrol, Tylenol, and Benadryl recommended per package insert.*

Please send Hep B Panel results with order, we cannot infuse without Hep B Panel documentation.

Labs:

☐ Draw CBC w/diff and CMP at each rituximab infusion

Other labs (include frequency): ______________________________

> **Port/PICC care per protocol will be performed if applicable including heparin flush (500 units/5mL) and cathflo (2 mg) PRN for patients with a port**

Other comments: ____

Prescriber Printed Name:____

Prescriber Full Address: ____

Office Phone Number: _______________________ **Office Fax Number:** _____________________

Prescriber Signature: ____ **Date:** __________________