MIC | METRO INFUSION CENTER

INFUSION ORDERS- RITUXAN (RITUXIMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
☐ Rheumatoid Arthritis (RA)	ICD10: M06.9
☐ Chronic Lymphocytic Leukemia (CLL)	ICD10: C91.10
☐ Other Diagnosis: _____	ICD10: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider ☐ Patient demographics AND insurance information	☐ Clinical/Progress notes supporting primary diagnosis ☐ Labs and Tests supporting primary diagnosis ☐ Hepatitis B Test Results: HBsAg & Total HepB Core Antibody

MEDICATION ORDERS**	
Dosing	☐ Rituxan 1000mg IV every 14 days for two doses ONLY ☐ Rituxan 1000mg IV every 14 days for two doses; Repeat every 6 months ☐ Rituxan 1000mg IV once ☐ Rituxan 375 mg/m² IV every _____ ☐ Other: Rituxan _____
Refills:	☐ X 6 months ☐ X 1 year ☐ _____ doses

PREMEDICATIONS
☐ Acetaminophen 650mg PO, 30-60 minutes prior to rituximab infusion
☐ Diphenhydramine 25mg PO, 30-60 minutes prior to rituximab infusion
☐ Methylprednisolone 100mg Slow IV Push, 30 minutes prior to infusion
☐ Other:

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: (877) 448-3627
Fax Completed Form and all documentation to: 866-507-1164