



Please fax completed form, insurance card, and clinical documentation to:
FAX: 843-793-6181

RITUXIMAB ORDER NEPHROLOGY

New Start Maintenance: Last Dose Given _____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	

Allergies NKDA Allergies: _____

Height: _____ Weight: _____

Indication:

I77.8 ANCA positive vasculitis

N04. Nephrotic Syndrome

N05. Focal Segmental glomerulonephritis

Other _____

DRUG: Rituxan | Truxima | Riabni | Ruxience

Rituximab-per insurance preferred

Rituxan

Truxima (rituximab-abbs)

Riabni (rituximab-arrx)

Ruxience (rituximab-pvvr)

<p>INDUCTION DOSES:</p> <p><input type="checkbox"/> 375mg/m2 every week X 4 weeks</p> <p><input type="checkbox"/> 1000mg IV at day 0 and 15 (approximately)</p> <p><input type="checkbox"/> Other _____</p>	<p>MAINTENANCE DOSES:</p> <p><input type="checkbox"/> 500mg IV at day 0 and 15 (approximately)</p> <p><input type="checkbox"/> 500mg IV every _____</p> <p><input type="checkbox"/> Other _____</p>
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PREMEDICATION ORDERS: *antihistamine, acetaminophen and 100mg methylprednisolone are recommended in the PI*

Acetaminophen po: 1000mg 500mg 30 min prior to infusion.

Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion.

Solu-Medrol: 62.5mg IVP 100mg IVP Other _____ 30 min prior to infusion.

Other _____

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
 - Insurance card(s) – copy of front & back
 - Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
- Most Recent Labs (within last 4-8 weeks) – Required:
- CBC CMP TB Hep B Other: _____