Rose Pharmacy
10008 Pines Blvd
Pembroke Pines, FL 33024
Phone: 954.432.8290
Fax: 844.246.3364

ROSE PHARMACY

INFUSION ORDERS- RITUXAN (RITUXIMAB)

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

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

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:
Office Phone:	Office Fax:	Email:
Prescriber Signature:		Date:

Contact us with questions at: info@rosenursing.net
or call **954.432.8290**

Fax completed form and all documentation to **844.246.3364**
All information contained in this form is strictly confidential and will become part of the patient's medical record.