FUSIONDRIP
HYDRATION & WELLNESS

Rituxan (rituximab) IV Infusion Order Form

Phone: 614-407-1621 Fax: 614-413-3877
orders@fusiondriphydration.com

Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / _____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **Weight:** _____ kg **Height:** _____ cm/in
- **Allergies:** ☐ NKDA ☐ _____
- **Treatment Status:** ☐ New ☐ Continued **Last Treatment Date:** ____ / ____ / ____

Diagnosis (ICD-10 Selection)

☐ C85.80 – Non-Hodgkin lymphoma, unspecified
☐ M06.9 – Rheumatoid arthritis, unspecified
☐ D59.10 – Autoimmune hemolytic anemia
☐ M31.30 – Wegener's granulomatosis without renal involvement
☐ M31.31 – Wegener's granulomatosis with renal involvement
☐ Other: _____ **ICD-10 Code:** _____

Infusion Order

- ☐ 375 mg/m² IV weekly × 4 doses
- ☐ 500 mg IV on Day 0 and Day 14
- ☐ 1000 mg IV on Day 0 and Day 14, repeat every 6 months
- ☐ Other: _____
- ☐ Infuse over ≥2–4 hours per manufacturer protocol
- ☐ Use 0.2-micron low-protein binding in-line filter
- ☐ Observation: ☐ 30 minutes post-infusion
- ☐ Refills: ☐ None ☐ 6 months ☐ 12 months ☐ Other: _____

Line Use & Access

☐ Start PIV ☐ Access CVC ☐ Use PICC Line ☐ Flush per standard infusion protocol

Adverse Reaction & Anaphylaxis Orders

☐ Fusiondrip Hydration & Wellness Center Protocol (fusiondriphydration.com)

☐ Other – please fax preferred reaction orders to 614-413-3877

☐ **Premedication (Required)**
☐ Acetaminophen: ☐ 650 mg ☐ 1000 mg ☐ PO
☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ Methylprednisolone: ☐ 100 mg ☐ 125 mg ☐ IV
☐ Cetirizine: ☐ 10 mg ☐ PO
☐ Other: _____ **Dose:** _____ **Route:** _____

Laboratory Monitoring

☐ CBC ☐ CMP ☐ CRP ☐ ESR
☐ Hepatitis B Panel (HBsAg and anti-HBc required prior to first dose)
☐ Other: _____
Frequency: ☐ Prior to first dose ☐ Each infusion ☐ Monthly ☐ Other: _____
☐ Physician office will order labs only

Clinical Documentation Checklist

☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list
☐ Documentation of prior therapies or intolerance
☐ Hepatitis B screening results

Ordering Provider & Demographics

- **Name:** _____
- **NPI:** _____ **License #:** _____
- **Contact:** _____ **Phone:** _____ **Fax:** _____
- **Email:** _____
- **Signature:** _____ **Date:** ____ / _____ / _____