DEHESA DERMATOLOGY

Dehesa Dermatology
978 N. Temperance Ave. Clovis CA 93611
(P) 559.951.9000 (F) 559. 234.6334
https://dehesadermatology.com

RITUXIMAB (RITUXAN) OR BIOSIMILAR INFUSION ORDER

Patient Information

Patient Name: _____

DOB: _____

Patient Height: _____
Patient Weight (kg): _____

Address: _____
_____

Phone: _____

Diagnosis: _____
ICD-10 Code: _____

Attach:
☐ Patient demographics
☐ Copy (front & back) of insurance card(s)
☐ Most recent clinical notes

Required (Results must accompany order)

☐ Hepatitis B Surface Antigen (HBsAg)
☐ Hepatitis B Core Antibody (Total Anti-HBc)
☐ Hepatitis C Screening
☐ Tuberculosis Screening (QuantiFERON-TB Gold or TST)
☐ Complete blood counts (CBC) with differential and platelets

---

Medication Order
☐ **Rituxan** _____ mg IV ☐ **Rituximab biosimilar** _____ mg IV

Dosing Regimen

Initial Dosing:

☐ _____ mg IV every 2 weeks × 2 doses
☐ _____ mg IV weekly × 4 doses

OR
☐ Other: _____

Maintenance Dosing:

☐ _____ mg IV every _____ months
☐ Other: _____

Pre-Medications (Administer 30 minutes prior to infusion)

☐ Acetaminophen 650 mg PO once
☐ Diphenhydramine 25–50 mg PO or IV once
☐ Methylprednisolone 100 mg IV once

PRN
☐ Diphenhydramine 25–50 mg IV PRN
☐ Methylprednisolone 125 mg IV PRN
☐ Famotidine 20 mg IV PRN
☐ Epinephrine 0.3 mg IM PRN anaphylaxis
☐ Albuterol 2.5 mg nebulized PRN bronchospasm
☐ Normal Saline IV bolus PRN hypotension
Call ordering provider for moderate/severe reaction

Additional Instructions

Ordering Physician:

Printed Name: _____

Signature: _____Date: _____

Contact Person: _____

Phone: _____Fax: _____

FAX ORDER TO 559.234.6334