Truxima Infusion Order

LivWell INFUSIONS

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

- ◯ M06.9 Rheumatoid arthritis, unspecified
- ◯ M05.79 Rheumatoid arthritis with rheumatoid factor without organ or systems involvement
- ◯ C85.90 Non-Hodgkin lymphoma, unspecified
- ◯ C91.10 Chronic lymphocytic leukemia
- ◯ M31.3 Wegener's granulomatosis
- ◯ Other _____

ICD-10 _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

- ◯ Clinical/ Progress Notes
- ◯ Demographics Sheet
- ◯ Current Medications
- ◯ Labs

TRUXIMA ORDER

Patients weight: _____ kg Patients Height:_____

Truxima Dose: ◯ Infused 1000mg ◯ 375 mg/m2 ◯ 500mg

Truxima Frequency: ◯ Every 4 weeks ◯ On Series Day 0 and Series Day 14: Repeat every 24 weeks

Other: _____

PreMeds: ◯ Diphenhydramine ◯ APAP ◯ IV methylprednisolone 100mg ◯ IV methylprednisolone 1000mg

Date of last Truxima Infusion: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____