**Date:** [Date]

**To:** [Infusion Center Name]
**Fax:** [Fax Number]
**From:** [Physician Name]
**Department:** Rheumatology

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## Patient Information

**Name:** [Patient Full Name]
**Date of Birth:** [DOB]
**Patient ID/MRN:** [ID Number]
**Diagnosis (ICD-10):** [Diagnosis Code and Description]

## Prescription Orders

**Medication:** [Drug Name, e.g., Rituximab, Infliximab]
**Dosage:** [e.g., 1000mg or 5mg/kg]
**Route:** Intravenous (IV) Infusion
**Frequency/Schedule:** [e.g., Week 0, 2, and 6, then every 8 weeks]
**Total Number of Refills:** [Number]

## Pre-Medications

- Acetaminophen: [Dose] mg PO 30 minutes prior to infusion
- Diphenhydramine: [Dose] mg PO/IV 30 minutes prior to infusion
- Methylprednisolone: [Dose] mg IV 30 minutes prior to infusion

## Clinical Monitoring

**Vitals:** Check every 15 minutes for the first hour, then every 30 minutes until completion.
**Infusion Rate:** Start at [Rate] mL/hr. Titrate as per standard protocol if tolerated.
**Post-Infusion:** Observe patient for [30/60] minutes post-procedure.

## Physician Authorization

**Physician Signature:** ____________________________
**NPI Number:** [NPI Number]
**Contact Phone:** [Phone Number]