Rituximab (Rituxan, Ruxience)

Provider Order Form rev. 01/02/2024

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Non-Hodgkin's Lymphoma: Chronic Lymphocytic Leukemia: Rheumatoid Arthritis:

Other: Description:

THERAPY ADMINISTRATION *(Select one)*

☐ Infuse rituximab (Rituxan) OR rituximab biosimilar as required by patient's insurance.

☐ Infuse this rituximab product (subject to prior authorization):

_____

DOSING

☐ Rituximab _____ mg IV

☐ Rituximab _____ mg/m2 x (Current BSA) _____ m2 = _____ mg *(Dose will be rounded up to 10% to nearest 100 mg per protocol unless specified below).*

☐ Dose rounding prohibited.

☑ Doses less than 500mg will go in final volume 250ml ml NS. Doses greater than 500mg will go in final volume 500 ml NS.

FREQUENCY

☐ Infuse on Day 0 and Day 14

☐ Infuse on Day 0, Day 7, Day 14, and Day 21

☐ Other: _____

☐ Repeat dosing in _____ weeks.

☐ Repeat dosing in _____ months.

PRE-MEDICATION ORDERS

☐ Loratadine 10mg PO

☑ Required Tylenol 500mg PO

☐ Solumedrol 125mg IV ***(Required for diagnosis of RA)***

☑ Required Benadryl 25 mg PO

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Signs/symptoms of infection, surgical procedures, recent live vaccines, neurological or mood changes.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, biologic agent and steroids, BSA of affected skin (by indication)

Required Labs: Include negative Hepatitis B, CBC w/diff platelets, renal function, CRP, ESR, for RA: Rheumatoid Factor, CCP

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.