LIFE SPECIALTY SOLUTIONS

# RITUXIMAB

(Including Rituxan and biosimilars: Riabni, Ruxience, Truxima)

## PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ EMAIL: _____

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

### REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List 6. Hep B Panel

## PRIMARY DIAGNOSIS

| | | |
|---|---|---|
| ☐ D59.10 Autoimmune hemolytic anemia, unspecified] | ☐ M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites | ☐ N01.7 Rapidly progressive nephrotic syndrome with diffuse crescentic glomerulonephritis |
| ☐ D89.1 Cryoglobulinemia | ☐ M06.89 Other specified rheumatoid arthritis, multiple sites | ☐ N03.2 Chronic nephritic syndrome with diffuse membranous glomerulonephritis |
| ☐ I77.6 Arteritis, unspecified | ☐ M06.9 Rheumatoid arthritis, unspecified | ☐ N04.2 Nephrotic syndrome with diffuse membranous glomerulonephritis |
| ☐ M05.10 Rheumatoid lung disease w/rheumatoid arthritis of unspecified site | ☐ M31.30 Wegener's granulomatosis without renal involvement | |
| ☐ M05.79 Rheumatoid arthritis with rheumatoid factor multiple sites without organ system involvement | ☐ M31.31 Wegener's granulomatosis with renal involvement | ☐ Other:_____ |
| ☐ M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified | ☐ M31.7 Microscopic polyangitis | |

## LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

## PRE-MEDICATIONS

☑ Per infusion clinic protocol: Acetaminophen 650mg PO, Diphenhydramine 25mg PO, and Methylprednisolone 100mg IV 30 minutes prior to infusion

☐ Provider Prescribed: _____

## PRIMARY MEDICATION ORDER

Rituxan or biosimilar (Ruxience, Riabni, Truxima) may be used according to payer guidelines.

To prohibit auto-substitution, please indicate specific brand required: _____

☐ Rituximab 1000mg IV on day 1 and day 15 every 6 months ☐ Rituximab 500mg IV on day 1 and day 15 every 6 months

☐ Rituximab 375mg/m2 (calculated dose_____mg) once weekly for 4 weeks

☐ Other _____ FIRST DOSE?: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted.

## LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)

☐ Other Flush Orders: Please send other line care orders if checking this box

## ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)

☐ Other: (Please send other reaction orders if checking this box)

## PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ EMAIL: _____

CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

✖ _____ _____

PROVIDER SIGNATURE DATE