



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

<input type="checkbox"/> D59.10 Autoimmune hemolytic anemia, unspecified <input type="checkbox"/> D89.1 Cryoglobulinemia <input type="checkbox"/> I77.6 Arteritis, unspecified <input type="checkbox"/> M05.10 Rheumatoid lung disease w/rheumatoid arthritis of unspecified site <input type="checkbox"/> M05.79 Rheumatoid arthritis with rheumatoid factor multiple sites without organ system involvement <input type="checkbox"/> M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified	<input type="checkbox"/> M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites <input type="checkbox"/> M06.89 Other specified rheumatoid arthritis, multiple sites <input type="checkbox"/> M06.9 Rheumatoid arthritis, unspecified <input type="checkbox"/> M31.30 Wegener's granulomatosis without renal involvement <input type="checkbox"/> M31.31 Wegener's granulomatosis with renal involvement <input type="checkbox"/> M31.7 Microscopic polyangitis	<input type="checkbox"/> N01.7 Rapidly progressive nephrotic syndrome with diffuse crescentic glomerulonephritis <input type="checkbox"/> N03.2 Chronic nephritic syndrome with diffuse membranous glomerulonephritis <input type="checkbox"/> N04.2 Nephrotic syndrome with diffuse membranous glomerulonephritis <input type="checkbox"/> Other: _____
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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 Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.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 Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.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: _____

X _____ DATE _____

PROVIDER SIGNATURE _____ DATE _____