

RITUXIMAB PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:



Patient Name:

Date of Birth:

Address:

Phone:

Height:

inches cm

Weight:

lbs kg

Clinical Information

Primary Diagnosis Description:

ICD-10 Code:

Is this the first dose?

Yes – date of first dose:

No – date of next dose due:

Hepatitis B Status:

Titer Date:

Positive Negative

TB Status:

PPD (negative) – date:

Active TB

Last chest x-ray – date:

Unknown

Past positive TB infection, course taken:

Rituximab Prescription

Rituximab (Rituxan®) Ruxience™ (rituximab-pvvr) Riabni (rituximab-arrx) or Rituximab-abbs (Truxima®) refill as directed x 1 year

Infuse 375 mg/m² IV once weekly for _____ doses.

Infuse 375 mg/m² IV on Day 1 of each chemotherapy cycle for up to _____ infusions.

Infuse 1000 mg IV on Week 0 and Week 2.

Other: _____

Dose will be rounded to closest 100 mg vial.

Ancillary Orders

Anaphylaxis Kit

- Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
 - Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
 - Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

Medication Orders

- Acetaminophen _____ mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may decline.
- Diphenhydramine _____ mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may decline.
- Methylprednisolone 100 mg IV over 15 to 60 min; 30 min prior to infusion.
- Other: _____

IV Flush Orders

- Peripheral: NS 2 to 3 mL pre-/post-use.
- Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

- No labs ordered at this time.
- Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____

Date: _____

Prescriber Information

Prescriber Name:

Phone:

Fax:

Address:

NPI:

City, State:

Zip:

Office Contact:

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