RITUXIMAB PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		
Phone:	**Height:** ☐ inches ☐ cm	**Weight:** ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description: **ICD-10 Code:**

Allergies: ☐ NKDA OR (List):

Is this the first dose? ☐ Yes – date of first dose: ☐ No – date of last dose:

Hepatitis B Status: Titer Date: ☐ Positive ☐ Negative

Rituximab Prescription

☐ **Rituximab biosimilar (e.g., Ruxience®, Riabni®, or Truxima®) as permitted by patient's insurance**

☐ **Rituximab (Rituxan®)**

- ☐ Infuse 375 mg/m^2 IV once weekly for _____ doses.
- ☐ Infuse 375 mg/m^2 IV on Day 1 of each chemotherapy cycle for up to _____ infusions.
- ☐ Infuse 1000 mg IV on Day 1 and Day 15.
  - ☐ Repeat every 6 months
- ☐ 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) SUBQ 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 – max 25mg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

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 Sodium Succinate 100 mg IV push over at least 5 min; 30 min prior to infusion.
- ☐ Other: _____

IV Flush Orders

- Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
- Implanted Port: 0.9% Sodium Chloride 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.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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:**

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

