

RITUXIMAB PRESCRIBER ORDER FORM					
Patient Name:				Date of Birth:	
Address:					
Phone:		Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg
Clinical Information					
Primary Diagnosis Description:				ICD-10 Code:	
Is this the first dose?		<input type="checkbox"/> Yes – date of first dose: <input type="checkbox"/> No – date of next dose due:		Hepatitis B Status: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
<input type="checkbox"/> Titer Date:					
Rituximab Prescription					
<input type="checkbox"/> Rituximab biosimilar (e.g., Ruxience™, Riabni, or Truxima®) as permitted by patient's insurance <input type="checkbox"/> Rituximab (Rituxan®)					
<input type="checkbox"/> Infuse 375 mg/m ² IV once weekly for _____ doses. <input type="checkbox"/> Infuse 375 mg/m ² IV on Day 1 of each chemotherapy cycle for up to _____ infusions. <input type="checkbox"/> Infuse 1000 mg IV on Week 0 and Week 2. <input type="checkbox"/> Other: _____ Dose will be rounded to closest 100 mg vial.					
Ancillary Orders					
Anaphylaxis Kit Dosage: <ul style="list-style-type: none"> ▪ 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 <input type="checkbox"/> Acetaminophen _____ mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may decline. <input type="checkbox"/> 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. <input type="checkbox"/> Methylprednisolone Sodium Succinate 100 mg IV push over at least 5 min; 30 min prior to infusion. <input type="checkbox"/> Other: _____					
IV Flush Orders <input type="checkbox"/> <u>Peripheral:</u> 0.9% Sodium Chloride 2 to 3 mL pre-/post-use. <input type="checkbox"/> <u>Implanted Port:</u> 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 <input type="checkbox"/> No labs ordered at this time. <input type="checkbox"/> 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>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>					
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:					
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