

RITUXIMAB PRESCRIBER ORDER FORM

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



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:	Titer Date: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
TB Status:	<input type="checkbox"/> PPD (negative) – date: <input type="checkbox"/> Last chest x-ray – date: <input type="checkbox"/> Past positive TB infection, course taken:	<input type="checkbox"/> Active TB <input type="checkbox"/> Unknown	

Rituximab Prescription

Rituximab (Rituxan®) *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
 ➔ Required per Option Care Health policy – please complete Anaphylaxis Physician Order (FR-PC-036) provided.

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 use own supply or 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 use own supply or 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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