RITUXIMAB PRESCRIBER ORDER FORM

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

option care health

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: ☐ Last chest x-ray – date: ☐ Past positive TB infection, course taken:	☐ Active TB ☐ Unknown

Rituximab Prescription

☐ **Rituximab (Rituxan®) *or* ☐ Rituximab-abbs (Truxima®) refill as directed x 1 year**

- ☐ 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 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:**	

