

RITUXIMAB PRESCRIBER ORDER FORM

FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES & LABS) to: (757) 466-1128

NEW PATIENT OR

CHANGE ORDER:

Drug Change

Dose Change

Interval Change

Patient Name:

Date of Birth:

Phone:

Gender:

Address:

Allergies:

Height: in cm

Weight: lbs kg

CLINICAL INFORMATION

Primary Diagnosis Description:

ICD-10 Code:

Is this the first dose?

Yes – Date of first dose: _____

Hepatitis B Status:

Titer Date: _____

No – Date of next dose due: _____

Positive

Negative

PRESCRIPTION

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

Rituximab (Rituxan®)

Infuse 1000mg IV on Week 0 and Week 2.

Other: _____

Dose will be rounded to the closest 100mg vial.

ANCILLARY ORDERS

Pre-Medication Orders

Acetaminophen _____ mg PO 30 minutes before infusion. Patient may decline.

Diphenhydramine _____ mg PO 30 minutes before infusion. Patient may decline.

Methylprednisolone Succinate 100mg IV push over at least 5 minutes; 30 minutes prior to infusion.

Cetirizine 10mg IV push over 1-2 minutes; 30 minutes before infusion. Patient may decline.

Other: _____

PRN Hypersensitivity Meds:

- Epinephrine 0.3mg
- Solu-Cortef 100mg
- Solu-Medrol 125mg
- Diphenhydramine 25-50mg
- NS 500 ML (>3kg)

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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