

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: _____
☐ No – Date of next dose due: _____

Hepatitis B Status: Titer Date: _____
☐ 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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