

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: Phone: Date of Birth:

Address:

Allergies:

Height: ☐ inches ☐ cm Weight: ☐ lbs ☐ kg

CLINICAL INFORMATION

Primary Diagnosis Description: ICD-10 Code:

Is this the first dose? ☐ Yes
☐ No – date of next dose due: _____

Treatments – Tried and Failed:

Hepatitis B Status: Titer Date: _____
☐ Positive ☐ Negative

TB Status: ☐ PPD (negative) – date: _____ ☐ Active TB ☐ Unknown
☐ Last chest X-ray – date: _____ ☐ Other: _____
☐ Past positive TB infection, course taken: _____

RITUXIMAB 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 650mg PO 30 minutes before infusion. Patient may decline.
☐ Diphenhydramine 25mg PO/IV 30 minutes before infusion. Patient may decline.
☐ Methylprednisolone Succinate 125mg IV push 20 minutes before infusion.
☐ Cetirizine 10mg IV push 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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