

RITUXIMAB ORDERS

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____ Phone: _____ Allergies: _____
 City, State, Zip: _____ Email: _____

REFERRAL STATUS

New Referral Dose or Frequency Change Order Renewal

Is this the first dose? Yes No, date of last infusion: _____ Line type: PIV PICC Port Other

DIAGNOSIS AND ICD 10 CODE

Rheumatoid Arthritis ICD-10 Code: _____
 Microscopic Polyangiitis ICD-10 Code: _____
 Granulomatosis w/Polyangiitis (Wegener's granulomatosis GPA) ICD-10 Code: _____
 Diagnosis: _____ ICD-10 Code: _____

REQUIRED DOCUMENTATION

This signed order form by the provider H&P and Clinical/Progress notes supporting primary diagnosis
 Patient demographics AND insurance information Labs and Tests supporting primary diagnosis

MEDICATION ORDERS

| | Dose | Frequency |
|-----------|--|--|
| Rituximab | <input type="checkbox"/> 375 mg/m2 <input type="checkbox"/> 1000 mg <input type="checkbox"/> 500 mg <input type="checkbox"/> Other: _____ | <input type="checkbox"/> One time dose <input type="checkbox"/> Week 0 and Week 2 <input type="checkbox"/> Week 0 and Week 2, then every _____ weeks x _____ doses <input type="checkbox"/> Every _____ weeks x _____ doses |

Dose may be rounded to nearest vial size within +/- 10%. TO PROHIBIT dose rounding check here:

Refills: X 6 months X 1 Year Other: _____
*(if not indicated, order will expire 1 year from date signed)

Preferred Brand: No Preference
 Rituxan Truxima Ruxience Riabni

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration
 RN to flush and lock VAD/CVAD per company protocol
 Other: _____

PREMEDICATION ORDERS

Acetaminophen 650mg PO prior to infusion Other: _____
 Diphenhydramine 25mg PO prior to infusion Other: _____
 Methylprednisolone 100mg Slow IV Push, 30 minutes prior to infusion Other: _____

EMERGENCY MEDICATIONS

Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
 Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
 Acetaminophen 325mg-650mg PO
 Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
 Epinephrine 0.3mg IM/SQ, may repeat x1
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
 Diphenhydramine 25mg slow IV push over 2-5 mins
 Acetaminophen 325mg PO
 Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
 Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____
 Office Phone: _____ Office Fax: _____
 Prescriber Signature: _____ Date: _____