

RITUXIMAB PRESCRIBER ORDER FORM

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



Patient Name:		Date of Birth:	
Address:			
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
Is this the first dose? <input type="checkbox"/> Yes – date of first dose: <input type="checkbox"/> No – date of next dose due:	Hepatitis B Status: Titer Date: <input type="checkbox"/> Positive <input type="checkbox"/> Negative

Rituximab Prescription

Rituximab (Rituxan®) Ruxience™ (rituximab-pvvr) Riabni (rituximab-arrx) or Rituximab-abbs (Truxima®)

Infuse 375 mg/m² IV once weekly for _____ doses.

Infuse 375 mg/m² 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

Dosage:

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

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 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 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:

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