

# Rituximab

(RITUXAN and biosimilars)

**PROVIDERS: Please include the following information to expedite the order:**  
Patient demographics, insurance information, most recent visit notes, Hep B results, and applicable labs

## PATIENT INFORMATION

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_  
ICD-10: (Required) \_\_\_\_\_ Description: \_\_\_\_\_  
Allergies: \_\_\_\_\_  NKDA Weight: \_\_\_\_\_  lb  kg  
Patient Status:  New to Therapy  Continuation of Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

## REFERRAL STATUS New Referral Updated Order Order Renewal

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_  
Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## NURSING

- Utilize hypersensitivity protocol established by Redeemer Health Infusion Therapy Center
- Provide nursing care and observation according to Redeemer Health Infusion Therapy Center policies and procedures
- Labs required to start, including HBsAg and Anti-HBc:  
\_\_\_\_\_
- Baseline liver enzymes, including bilirubin:  
\_\_\_\_\_

## THERAPY ADMINISTRATION

- Rituximab  
**MUST SELECT PREFERRED PRODUCT.** If preferred product is not covered or the insurance company requires a specific alternative, we will contact your practice.  
 RITUXAN  
 Biosimilar (must indicate specific product): \_\_\_\_\_
- Dose:**
  - 375mg/m<sup>2</sup>
  - 500mg
  - 1000mg
- Rate:** administer according to package insert
- Frequency:**
  - Day 0 and Day 14, repeat series every \_\_\_\_\_ weeks
  - Once weekly for 4 weeks
  - Other \_\_\_\_\_
- Route:** intravenous infusion
  - Flush with 0.9% sodium chloride after infusion complete
  - Patient is required to stay for 30-minute observation
- Refills:**  No Refills  12 months  \_\_\_\_\_

## LABORATORY ORDERS

- CBC  at each dose  every \_\_\_\_\_
- CMP  at each dose  every \_\_\_\_\_
- CRP  at each dose  every \_\_\_\_\_
- Other: \_\_\_\_\_
- Please check this box if you do NOT authorize Redeemer Health Infusion Therapy Center to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

## PRE-MEDICATION ORDERS

- acetaminophen (TYLENOL)  500 mg  650 mg  1000 mg PO
- cetirizine (ZYRTEC) 10 mg PO
- loratadine (CLARITIN) 10 mg PO
- diphenhydramine (BENADRYL)  25 mg  50 mg |  PO  IV
- methylprednisolone (SOLU-MEDROL)  40 mg IV  125 mg IV
- hydrocortisone (SOLU-CORTEF) 100 mg IV

## SPECIAL INSTRUCTIONS

Redeemer Health Infusion Therapy Center will conduct peer-to-peer review(s) on behalf of the prescribing provider for any insurance denials. If you DO NOT AUTHORIZE Redeemer Health Infusion Therapy Center to do this on your behalf, check this box.

**Note to prescriber:** Pre-medicate patients with an antihistamine and acetaminophen prior to dosing. For RA and PV patients, methylprednisolone 100 mg intravenously or its equivalent is recommended 30 minutes prior to each infusion. Screen all patients for HBV infection by measuring HBsAg and anti-HBc before initiating treatment with rituximab. For patients who show evidence of prior hepatitis B infection (HBsAg positive [regardless of antibody status] or HBsAg negative but anti-HBc positive), consult with physicians with expertise in managing hepatitis B regarding monitoring and consideration for HBV antiviral therapy before and/or during rituximab treatment.

Provider Name (Print): \_\_\_\_\_ Provider Signature (No Stamps): \_\_\_\_\_ Date: \_\_\_\_\_