Rituximab

(Including Rituxan & Biosimilars: Riabni, Ruxience, Truxima)

Advanced Infusion Care Centers

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

- ☐ D59.10 Autoimmune hemolytic anemia, unspecified
- ☐ D89.1 Cryoglobulinemia
- ☐ I77.6 Arteritis, unspecified
- ☐ M05.10 Rheumatoid lung disease w/rheumatoid arthritis of unspecified site
- ☐ M05.79 Rheumatoid arthritis with rheumatoid factor multiple sites without organ system involvement
- ☐ M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified
- ☐ M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites
- ☐ M06.89 Other specified rheumatoid arthritis, multiple sites
- ☐ M06.9 Rheumatoid arthritis, unspecified
- ☐ M31.30 Wegener's granulomatosis without renal involvement
- ☐ M31.31 Wegener's granulomatosis with renal involvement
- ☐ L10.0 Pemphigus vulgaris
- ☐ M31.7 Microscopic polyangiitis
- ☐ N01.7 Rapidly progressive nephrotic syndrome with diffuse crescentic glomerulonephritis
- ☐ N03.2 Chronic nephritic syndrome with diffuse membranous glomerulonephritis
- ☐ N04.2 Nephrotic syndrome with diffuse membranous glomerulonephritis
- ☐ Other: _____

PRESCRIPTION

Rituxan or biosimilar (Ruxience, Riabni, Truxima) may be used according to payer guidelines.

*To prohibit auto-substitution, please indicate specific brand required: _____

☐ Rituximab 1000mg IV on Day 1 and Day 15, repeat course 24 weeks after initial dose. Refill x 1 year.

☐ Rituximab 375mg/m^2 once weekly for 4 weeks. Refill x 1 year.

☐ Other: _____

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Medication List
- Hep B Panel: HBsAg, HBsAb (anti-HBs), HBcAb (anti-HBc)

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*

☐ Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

☐ Per infusion center protocol: Methylprednisolone 100mg IV, diphenhydramine 25mg IV, acetaminophen 650mg PO 30 mins prior to infusion

☐ Provider Prescribed: _____

LINE CARE ORDERS

☑ Start PIV/Access CVC ☑ Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*

☐ Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.