oasis
FAMILY HEALTH NP RN

Fax: (845) 827-1272
Phone: (845) 827-3528
E-mail: intake@oasisivs.com

Rituximab (Rituxan)

PATIENT INFORMATION

Referral Status *(check one)*: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: ____________________ DOB: __________

NKDA ☐ Allergies: ____________________ Weight ______ *Please specify:* ☐ lbs ☐ kg Height: ______

Patient Status *(check one)*: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: __________ Next Due Date: __________

ICD-10 code (required): __________ ICD-10 description: ____________________

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ Hepatitis B status and date (Please provide results)

____

PRE-MEDICATION ORDERS*

The following are manufacturer recommended premedication regimens:

☐ acetaminophen (Tylenol) Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

PRE-MEDICATION ORDERS (ADDITIONAL)

☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ Other: ____________________
Dose: __________ Route: __________
Frequency: ____________________

* 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 RITUXAN. 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 RITUXAN treatment.

THERAPY ADMINISTRATION

Many payors require patients start therapy with a rituximab biosimilar.
Choose ONE of these two options:

☐ 1. Infuse rituximab (Rituxan) OR rituximab biosimilar as required by patient's insurance.
☐ 2. Infuse this rituximab product (subject to prior authorization):
____
(Products include: Rituxan, Truxima, and Ruxience)

☐ Mix 0.9% sodium chloride or D5W to final concentration of 1-4mg/ml

- Dose: ☐ 1000mg / ☐ ________ mg
- Mix in: ☐ 500ml / ☐ 250ml
- Frequency: ☐ On Series Day 0 and Series Day 14; repeat series every 24 weeks ☐ Other: __________
- Infusion rate: First infusion in series: 50mg/hr, increasing every 30 minutes by 50mg/hr to maximum of 400mg/hr
- Subsequent infusion in series: 100mg/hr, increasing every 30 minutes by 100mg/hr to maximum of 400mg

☐ Flush with 0.9% sodium chloride at infusion completion

☐ Patient is required to stay for 30-minute observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ __________
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: __________ Referral Coordinator Email: __________

Ordering Provider: __________ Provider NPI: __________

Referring Practice Name: __________ Phone: __________ Fax: __________

Practice Address: __________ City: __________ State: ______ Zip Code: ______

Provider Name (Print) ____________________ *Provider Signature* ____________________ *Date* __________

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK