

# Rituximab (Ruxience)

## 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