MRN:_____

DOB:_____

STANDARD Rituxan® (rituximab) PLAN OF TREATMENT

NOTE: Patient ***may be ineligible*** to receive rituximab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, newly diagnosed cardiac arrhythmias, severe abdominal pain or vomiting, and/or surgery.

1. Patient Name:_____ Height (inches):_____ Weight (lbs):_____

2. Allergies: _____

3. Diagnosis: *** Please complete the 2nd and 3rd digits to complete the ICD-10 code for billing**

☐ **M05.**_____ Rheumatoid Arthritis with Rheumatoid factor ☐ **M06.**_____ Rheumatoid Arthritis without Rheumatoid factor

☐ Other **ICD-10 Code:**_____ Diagnosis description: _____

4. Pre-medications: *Administered 30 minutes prior to infusion* ***as selected:***

**** Premedication of Acetaminophen PO, Diphenhydramine IVP, and Methylprednisolone IVP is suggested prior to infusion***

Acetaminophen:	**Diphenhydramine:** □ 25 mg IVP, □ 50 mg IVP, □ 25 mg PO, □ 50 mg PO or
□ 650 mg PO	Alternate oral antihistamine to diphenhydramine:
□ 500 mg PO	□ Cetirizine 10 mg □ Loratadine 10 mg Fexofenadine □ 60mgs or □ 180mgs
□ 325 mg PO	**Methylprednisolone:** □ 125 mg IVP □ 40 mg IVP or other_____ mg IVP
□ 1000 mg PO	Famotidine: □ 20 mg PO, □ 40 mg PO, □ 20 mg IVP, □ 40 mg IVP

Pre-medicate with other: _____

5. DOSE:

☐ Rituxan® (rituximab) 1000mg IV per 500ml Sodium Chloride 0.9% to infuse per protocol ***OR***

☐ Other Dose: _____

6. FREQUENCY:

☐ Infuse at 0 week and 2 weeks ***every 4 months (16 weeks) OR***

☐ Infuse at 0 week and 2 weeks ***every 6 months (24 weeks)***

Special orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

7. Physician's Signature:_____/_____ Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____ NPI: _____

MRN:_____

DOB:_____

Guidelines for Prescribing Rituxan® (rituximab)

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:**_____

☐ Include signed and completed **Plan of Treatment**.

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

• Rheumatoid Arthritis (RA) Rituxan® (rituximab) in combination with methotrexate is indicated for the treatment of adult patients with moderately- to severely- active rheumatoid arthritis who have had an inadequate response to one or more TNF antagonist therapies. If patient is unable to take methotrexate, then MD must include supporting documentation as to reason/rational.

☐ If patient is switching biological therapies, then MD must specify wash-out period prior to starting Rituxan® as specified of_____weeks. Last known biological therapy:_____and last date received:_____. (Include copy of last Rituxan® infusion record if available and currently on therapy)

☐ Other as requested: _____

_____

_____

Pre-Screening:

☐ **Required Hepatitis screening to include: Hepatitis B Surface Antigen (HBsAg) and Total Hepatitis B Core Antibody (anti- HBc)**

***Rituxan® is contraindicated in patient with active HBV. Patients who are negative for surface antigen HBsAg (-) and positive for HB core antibody HBcAB (+) or positive for surface antigen HBsAg (+), should consult liver disease experts before starting and during treatment.**

** Warnings/Precautions: • **Hepatitis B Virus Reactivation**- Screen all patients for HBV infection by measuring HBsAg and anti-HBc (antibodies) before initiating treatment with Rituxan®. For patients who show evidence of prior hepatitis B infection (HBsAg positive 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. HBV reactivation has been reported up to 24 months following completion of Rituxan® •Glucocorticoids administered methylprednisolone IV premed or its equivalent 30 minutes prior to each infusion are recommended to reduce the incidence and severity of infusion reactions. • Subsequent courses should be administered every 24 weeks or based on clinical evaluation, but not sooner than every 16 weeks. Evaluation of immunizations should be completed prior to and live vaccines should not be given before or concurrently. **Serious Infections:** including fatal, bacterial, fungal, and new or reactivated viral infections can occur during and following the completion of Rituxan®. See full prescribing information.

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.