MRN:______________________

Phone: 1-800-809-1265 Fax: 1-866-872-8920 DOB:______________________

STANDARD Riabni™ (rituximab-arrx) PLAN OF TREATMENT for Rheumatology

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:

☐ Riabni™ (rituximab-arrx) 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: ________________

8. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com

Revised 07/11/2022

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DOB:______________________

Guidelines for Prescribing Riabni™ (rituximab-arrx)

(Required documentation with all initial referrals)

Patient Name: ____ **Referral Date:**____________________

___ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-8)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

___ 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) Riabni™ (rituximab-arrx) 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 Riabni™ as specified of_________weeks. Last known biological therapy:_______________and last date received:_____________. (Include copy of last rituximab-arrx infusion record if available and currently on therapy)

___ Other as requested: ____
____
____

Required Pre-Screening:

___ **Hepatitis B screening test completed. Results** (positive or negative): ________________________
***If Hep B results are positive, please send documentation of treatment or medical clearance.**

** Warnings/Precautions: • **Hepatitis B Virus Reactivation**- Screen all patients for HBV infection by measuring HBsAg and anti-HBc (antibodies) before initiating treatment with rituximab-arrx. 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 rituximab-arrx treatment. HBV reactivation has been reported up to 24 months following completion of rituximab-arrx •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 rituximab. See full prescribing information.

AccuRx Infusion 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.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.

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.