

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order change	<input type="checkbox"/> Order change
Patient preferred clinic:	

## Rituximab Unspecified Rheumatology Plan of Treatment

### PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:
Patient Name:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG
Gender:	Allergies:
	<input type="checkbox"/> See list <input type="checkbox"/> NKDA

### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

M05._____ - Rheumatoid arthritis with Rheumatoid factor
M06._____ - Rheumatoid arthritis without Rheumatoid factor
M05.79 - Rheumatoid arthritis with rheumatoid factor of multiple sites, without organ or systems involvement
_____ - Other:

### REQUESTED DOCUMENTATION:

### PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Most recent labs including CBC with diff	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Full medication list / Tried and failed therapies	FROM PREVIOUS	
5	<b>REQUIRED:</b> Hepatitis B Panel for new start patients	THERAPY:	<b>IF ORDER CHANGE:</b>
			<b>Continue current order until insurance approved</b>

### MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive rituximabf 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.

### PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

\*Per FDA labeling, Acetaminophen PO, Diphenhydramine IVP, and Methylprednisolone IVP is suggested prior to infusion

IV	Diphenhydramine	25mg	50mg		PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					Fexofenadine	60mg	180mg		
						Cetirizine	10mg			
					Loratadine	10mg				
					Other:					

### DRUG PRODUCT:

- Rituxan
- Ruxience
- Truxima
- Riabni

**Biosimilar may be used according to payer guidelines**

If selected, prescriber must sign substitution permitted line

### DOSE:

<input type="checkbox"/> 1000mg IV per 500ml NS to infuse per step protocol
<input type="checkbox"/> Other: _____

### FREQUENCY:

<input type="checkbox"/> Infuse at 0 and 2 weeks every 4 months (16 weeks)
<input type="checkbox"/> Infuse at 0 and 2 weeks every 6 months (24 weeks)
<input type="checkbox"/> Other: _____

### SPECIAL/LAB ORDERS:

<input type="checkbox"/>	_____
<input checked="" type="checkbox"/>	Refills x 12 months unless noted otherwise here:

**Prescriber to monitor patient for symptoms of HBV infection and reactivation as clinically appropriate.**

### LINE USE/CARE ORDERS:

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure

### ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.



### PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

### PRESCRIBER SIGNATURE: (No stamp signatures)

DATE

_____	_____
Dispense as written/Brand medically necessary	Substitution permitted