Palmetto INFUSION®

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

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
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:	☐ See list ☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD 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 invovement
- ☐ _____ - 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 REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Most recent labs including CBC with diff		NEXT INFUSION DATE:
4	Full medication list / Tried and failed therapies		**IF ORDER CHANGE:**
5	**REQUIRED:** Hepatitis B Panel for new start patients		☐ **Continue current order until insurance approved**

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						
	Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:					
	Famotidine	☐ 20mg	☐ 40 mg						
	Other:	☐							
PO	Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg	☐ 1000mg				
	Famotidine	☐ 20mg	☐ 40mg						
	Diphenhydramine	☐ 25mg	☐ 50mg						
	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

FREQUENCY:

- ☐ Infuse at 0 and 2 weeks every 4 months (16 weeks)
- ☐ Infuse at 0 and 2 weeks every 6 months (24 weeks)
- ☐ Other:_____

DOSE:

- ☐ 1000mg IV per 500ml NS to infuse per step protocol
- ☐ Other:_____

SPECIAL/LAB ORDERS:

- ☐ _____
- _____

☑ 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	