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:

| | |
|---|---|
| 1 | Insurance information |
| 2 | Most recent History & Physical |
| 3 | Most recent labs including CBC with diff |
| 4 | Full medication list / Tried and failed therapies |
| 5 | **REQUIRED**: **HBsAg, anti-HBc, and anti-HBs** |

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

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:
LAST INFUSION DATE:
NEXT INFUSION DATE:

**IF ORDER CHANGE:**

☐ **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: | ☐ | | | | | | |

### SPECIFIC MEDICATION:

- ☐ Rituxan
- ☐ Ruxience
- ☐ Truxima
- ☐ Riabni

☐ **Any rituximab biosimilar may be used according to payer guidelines**

### 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:

☐ _____

_____

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

☑ Refills x 12 months unless noted otherwise here:

## NURSING ORDERS:

- ☑ Start PIV/Access CVC
- ☑ Flush device per facility standard flushing procedure
- ☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

## 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 | |