

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

## Rituximab Unspecified Rheumatology Plan of Treatment

Rev 4.29.25

### PATIENT DEMOGRAPHICS:

Patient Name:	
Patient's Phone:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG Gender: Allergies: See list 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 FROM PREVIOUS THERAPY: NEXT INFUSION DATE:
4 Full medication list / Tried and failed therapies	IF ORDER CHANGE:
5 <b>REQUIRED: HBsAg, anti-HBc for new start patients</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		
	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:

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

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

### 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