

PRESCRIPTION ORDER FORM

RITUXIMAB

(Including Rituxan and biosimilars: Riabni, Ruxience, Truxima)



Central Fax: 800-504-0870

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List • Hep B Panel

PRIMARY DIAGNOSIS

☐ D59.10 Autoimmune hemolytic anemia, unspecified	☐ M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites	☐ N01.7 Rapidly progressive nephrotic syndrome with diffuse crescentic glomerulonephritis
☐ D89.1 Cryoglobulinemia	☐ M06.89 Other specified rheumatoid arthritis multiple sites	☐ N03.2 Chronic nephritic syndrome with diffuse membranous glomerulonephritis
☐ I77.6 Arteritis, unspecified	☐ M06.9 Rheumatoid arthritis, unspecified	☐ N04.2 Nephrotic syndrome with diffuse membranous glomerulonephritis
☐ M05.10 Rheumatoid lung disease w/rheumatoid arthritis of unspecified site	☐ M31.30 Wegener's granulomatosis without renal involvement	☐ Other: _____
☐ M05.79 Rheumatoid arthritis with rheumatoid factor multiple sites without organ system involvement	☐ M31.31 Wegener's granulomatosis with renal involvement	
☐ M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified	☐ M31.7 Microscopic polyangitis	

CLINICAL MONITORING: Recommended lab to be maintained and monitored by prescriber

☒ CBC q 2-4 months ☒ Creatinine Periodically

PRE-MEDICATIONS (15 - 20 MINS BEFORE INFUSION)

☐ Diphenhydramine 25mg PO	☐ Pepcid 20mg PO	☒ Cetirizine 10mg PO	☒ Solu-medrol 40mg IVP
☐ Diphenhydramine 50mg PO	☐ Pepcid 20mg IVP	☒ Tylenol 650mg PO	☐ Solu-medrol 125mg IVP
☐ Diphenhydramine 25mg IVP			☐ Other: _____
☐ Diphenhydramine 50mg IVP			

PRIMARY MEDICATION ORDER: If necessary, Suite Life will round dose up/down according to payor guidelines

Rituxan or biosimilar (Ruxience, Riabni, Truxima) may be used according to payer guidelines.

To prohibit auto-substitution, please indicate specific brand required : _____

☐ Rituximab 1000mg IV on day 1 and day 15 then repeat cycle day 1 and day 15 every 6 months - taper infusion rate

☐ Rituximab 500mg IV on day 1 and day 15 then repeat cycle day 1 and day 15 every 6 months - taper infusion rate

☐ Rituximab 375mg/m2 (calculated dose _____ mg) once weekly for 4 weeks - taper infusion rate

☐ Other: _____

First Dose: ☐ Y ☐ N ☒ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☒ Start PIV/ACCESS CVC ☒ Flush device per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)

☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☒ Administer acute infusion and anaphylaxis medications per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI AND License:	☐ Email:

Provider Signature

Date

Rev: 10/25