Phone: 608-690-7210
Fax: 608-807-5179
www.MySmartInfusion.com

Location
☐ Eau Claire ☐ Weston
☐ Middleton ☐ Onalaska

Rituximab (and Biosimilars)

Infusion Order Form

Patient Name: _____ DOB: _____ M ☐ F ☐

Allergies: _____

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

☐ Rheumatoid Arthritis ICD 10 Code: M05.___ M06.___ ☐ Microscopic Polyangiitis ICD 10 Code: M 3 1 . 7

☐ Granulomatosis with Polyangiitis ICD 10 Code: M31.___ ☐ Pemphigus Vulgaris ICD Code: L10.0

☐ Other: _____ ICD 10 Code:_____

Required Labs

TB/QuantiFERON Negative on_____

☐ May proceed with infusion with additional testing every____years

☐ No follow up testing necessary

Hepatitis B Status & Date: _____

Pre-Medication Orders

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ **PO** ☐ **IV**

Methylprednisolone (Solu-Medrol) ☐ 125mg IV

Ondansetron (Zofran) ☐ 4mg ☐ **PO** ☐ **IV**

Other: _____ Route: _____

Dose: _____ Frequency: _____

Medication Order Patient

☐ Rituxin (rituximab)

☐ Truxima (rituximab-abbs)

☐ Ruxience (rituximab-pvvr)

Will substitute Rituxin (rituximab) for biosimilar or referenced product based on insurance and availability.

OR

☐ **Dispense as Written**

Dosage

☐ 500mg IV ☐ 1000mg IV Other: _____

Frequency

☐ Induction week 0 and week 2 then one dose every 6 months

☐ Other _____

Adverse Reaction Management & Nursing Orders

Full protocols are available for review at mysmartinfusion.com or upon request.

☒ Administer the following emergency medications per Smart Infusion Therapy Services protocol:
- ☒ Acetaminophen 650mg PO,
- ☒ Diphenhydramine 25mg-50mg PO or IV
- ☒ Ondansetron 4mg IV
- ☒ Sodium Chloride 0.9% 1000mL IV
- ☒ Methylprednisolone 125mg IV
- ☒ Albuterol Sulfate 2.5mg nebulized
- ☒ Oxygen 1-6LPM continuous flow
- ☒ Epinephrine 0.3mg/0.3mL IM

☐ Other: _____

☒ Manage VAD per protocol:

☒ Start/Access and Discontinue PIV/CVC

☒ Flush with NS and/or Heparin per protocol based on line type

☒ Other: _____

Required Documents

☐ Patient Demographic Sheet
☐ H & P within the past 6 months
☐ Current Medication List
☐ Clinical & Progress Notes (including last infusion note)
☐ Copy of Insurance Card (Front/Back)

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____