Infusion Solutions Inc.
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RITUXAN (RITUXIMAB) ORDER FORM

PATIENT NAME:_____ DOB:_____ WT:_____ HT:_____

ALLERGIES:_____

DIAGNOSIS

HAS THE PATIENT PREVIOUSLY RECEIVED: RITUXAN (RITUXIMAB) ☐ NO ☐ YES

BRAND:_____ LAST DOSE DATE: _____

DIAGNOSIS: _____ ICD 10 CODE(S): _____

Infusion Solutions will select therapeutically interchangeable rituximab product based on payor requirements, product availability, and indication: 1) Rituxan (rituximab) ; 2) Truxima (rituximab-abbs); 3) Ruxience (rituximab-pvvr); 4) Riabni (rituximab-arrx)

☐ Substitution Permitted ☐ Dispense as written (indicate brand):_____

MEDICATION ORDERS

DOSE:
- ☐ 500 mg
- ☐ 1000 mg
- ☐ 375 mg/m2
- ☐ Other:_____

FREQUENCY:
- ☐ Day 0 and 14, x 1 course
- ☐ Day 0 and 14, repeat in 6 months
- ☐ Day 0, 7, 14, and 21, x1 course
- ☐ Other:_____

PREMEDICATION: 15-30 minutes prior to infusion

Diphenhydramine 50 mg IV ☐ PO ☐
Diphenhydramine 25 mg IV ☐ PO ☐
Cetirizine 10 mg PO ☐
Acetaminophen 1000 mg PO ☐
Acetaminophen 500 mg PO ☐
Methylprednisolone 100 mg IV ☐
Other (include dose and route): ☐
_____

Orders are valid for 1 year. For a shorter duration, indicate here:_____

STANDARD IV ORDERS

ANCILLARY ORDERS:
- Infusion Reaction Management per Infusion Solutions Protocol.
- Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- Flush with 0.9% NaCl and/or Heparin 10 u/ml or 100 u/ml per Infusion Solutions protocol.
- Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).

NURSING ORDERS:
- If no central IV access, RN to insert peripheral IV.
- Obtain weight before each dose.
- Monitor vital signs (temp, HR, RR, BP) before therapy, and every 15-30 minutes or with each rate change.
- If an infusion reaction occurs, decrease rate and monitor vital signs until symptoms subside. If the reaction persists or worsens, stop the infusion, initiate reaction protocol, and notify physician.
- Observe patient for 30 minutes after completion of therapy.

LABS

LAB ORDERS:

☐ CBC w/ diff ☐ CRP
☐ CMP ☐ Other:_____

LAB FREQUENCY:

☐ Every dose
☐ Other:_____

REQUIRED DOCUMENTATION

REQUIRED CLINICAL DOCUMENTS:
- Hepatitis B serology labs or proof of immunity/vaccination

RECOMMENDED CLINICAL DOCUMENTS (provide if available):
- Baseline Labs (CBC w/diff, CMP)
- Tests for cytomegalovirus, herpes simplex virus, parvovirus B19, varicella zoster virus, West Nile virus, hepatitis B and C

SUPPORTING DOCUMENTS:
- Patient demographic information and insurance information.
- Copy of front & back of insurance card if available.
- Patient's medication list.
- Supporting clinical notes, including past tried and/or failed therapies.

PROVIDER INFORMATION

_____ _____

PRESCRIBER SIGNATURE (substitution permitted) *PRESCRIBER SIGNATURE (dispense as written)*

_____ _____

PRINT NAME (FIRST AND LAST) *DATE*