

DIAGNOSIS: CD 10 CODE(S): Infusion Solutions will salect therapeutically interchangeable ritusimats product based on payor requirements, product availability, and indication 1) Rituxan (ritusimab): 2) Trustima (ritusimab-abbs): 39 Ruxiance (rituximab-pvvr): 4) Riabrii (rituximab-arrx) CD 10 CODE(S): Infusion Solutions will salect therapeutically interchangeable rituximab product based on payor requirements, product availability, and indication 1) Rituxan (rituximab-): 2) Trustima (rituximab-abbs): 39 Ruxiance (rituximab-pvvr): 4) Riabrii (rituximab-arrx) CD 10 CODE(S): Infusion Solution Permitted Dispense as written (indicate brand): Day 0 and 14, x 1 course Day 0 and 14, x 1 course Dispense as written (indicate brand): Day 0 and 14, x 1 course Dispense as written (indicate brand): Day 0 and 14, x 1 course Dispense as written (indicate brand): Day 0 and 14, x 1 course Dispense as written (indicate brand): Day 0 and 14, x 1 course Dispense as written (indicate brand): Day 0 and 14, x 1 course Dispense (indicate brand): Day 0 and 14, x 1 course Day 0 and 14, x 1 course Dispense (indicate brand): Day 0 and 14, x 1 course		RITUXAN (RITU)	XIMAB) ORD	ER F	FORM	
BIAGNOSIS AS THE PATIENT PREVIOUSLY RECEIVED: RITUXAN (RITUXIMAB)	PATIENT NAME:		DOB:		WT:	HT:
HAS THE PATIENT PREVIOUSLY RECEIVED: RITUXAN (RITUXIMAB) CAST DOSE DATE: Infusion Solutions will select therapeutically interchangeable rituximab product based on payor requirements, product availability, and indication 1) Rituxan (rituximab); 2) Trustime (rituximab-bash); 3) Ruxience (rituximab-pvvr); 4) Riabini (rituximab-arrx) Substitution Permitted Dispense as written (indicate brand):	ALLERGIES:					
Substitution Permitted	BRAND:	'ED: RITUXAN (RITU)	XIMAB) .AST DOSE DAT		_ ICD 10 CODE(S):	
DOSE: FREQUENCY: Day 0 and 14, x 1 course Day 0 and 14, repeat in 6 months Day 0, 7, 14, and 21, x1 course Day 0, 7, 14, and 21, x1 course Day 0, 7, 14, and 21, x1 course Diher: Day 0, 7, 14, and 21, x1 course Diher: Diherilydramine 50 mg IV PO Acetaminophen 1000 mg PO Other (include dose and route): Diphenhydramine 25 mg IV PO Acetaminophen 500 mg PO Other (include dose and route): Diphenhydramine 25 mg IV PO Acetaminophen 500 mg PO Other (include dose and route): Diphenhydramine 25 mg IV PO Acetaminophen 500 mg PO Other (include dose and route): Diphenhydramine 25 mg IV PO Acetaminophen 500 mg PO Other (include dose and route): Diphenhydramine 25 mg IV PO Acetaminophen 500 mg PO Other (include dose and route): Diphenhydramine 25 mg IV PO Acetaminophen 500 mg PO Other (include dose and route): Diphenhydramine 25 mg IV PO Acetaminophen 500 mg PO Other (include dose and route): Diphenhydramine 25 mg IV Diphenhydramine 25 mg IV PO Acetaminophen 500 mg PO Other (include dose and route): Diphenhydramine 25 mg IV Diphenhydramine 25 mg IV PO Acetaminophen 500 mg PO Other (include dose and route): Diphenhydramine 25 mg IV Diphenhydramine 25 mg	1) Rituxan (rituximab) ;	2) Truxima (rituximab-a	bbs); 3) Ruxience	rituxir	mab-pvvr); 4) Riabni (rituximab-a	arrx)
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Diphenhydramine 50 mg IV	□ 500 mg □ 1000 mg □ 375 mg/m2	FREQUENCY: □ Day 0 and 1 □ Day 0 and 1 □ Day 0, 7, 14	4, x 1 course 4, repeat in 6 m 4, and 21, x1 cou	onths rse		
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 w/ml or 100 w/ml per Infusion Solutions protocol. Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio). LAB ORDERS: CBC w/ diff CRP CMP Other: 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 PROVIDER INFORMATION PRESCRIBER SIGNATURE (substitution permitted) NURSING ORDERS: If no central IV access, RN to insert peripheral IV. Obtain weight before each dose. Mintor 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 FREQUENCY: Every dose Other: PREPORTING 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.	Diphenhydramine 50 mg IV PO Diphenhydramine 25 mg IV PO Cetirizine 10 mg PO	Acetaminoph Acetaminoph	nen 500 mg PO		• •	
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□ CBC w/ diff □ CRP □ Other: □ Other: □ Other: □ Other: □ CMP □ Other: □ Other: □ CMP □ Other: □ Other: □ CMP □ Other:	 Infusion Reaction Management per I Protocol. Alteplase 2mg IV to declot central IV Infusion Solutions protocol as neede Flush with 0.9% NaCl and/or Hepariu/ml per Infusion Solutions protocol. Lidocaine 1% - up to 0.2ml intraderm 	access per d for occlusion. n 10 u/ml or 100 nally PRN (may in 10:1 ratio).	 If no cer Obtain w Monitor 15-30 m If an infusigns un stop the Observe 	tral IV veight to vital signitutes vision re til symi	access, RN to insert periphera before each dose. gns (temp, HR, RR, BP) before or with each rate change. eaction occurs, decrease rate a ptoms subside. If the reaction on, initiate reaction protocol, an	e therapy, and every and monitor vital persists or worsens, d notify physician.
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 PROVIDER INFORMATION Other: 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)	LAB ORDERS:		LAB FREQUE	NCY:		
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