Infusion Solutions Inc.
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RITUXIMAB (or biosimilar) 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 IV
☐1000 mg IV
☐375 mg/m^2 IV
☐Other: _____

FREQUENCY:
☐Day 0 and 14, x 1 course
☐Day 0 and 14, repeat 2 dose treatment cycle in 6 months
☐Day 0, 7, 14, and 21, x 1 course
☐Other:_____

PREMEDICATION: 30 minutes prior to infusion

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

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

STANDARD 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 0.2 ml 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 provider.
- 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
- Baseline labs (CBC w/diff, CMP)

RECOMMENDED CLINICAL DOCUMENTS (provide if available):

- Tests for cytomegalovirus, herpes simplex virus, parvovirus B19, varicella zoster virus, West Nile virus, hepatitis B and C

SUPPORTING DOCUMENTS:

- Patient demographic and insurance information.
- Copy of front and 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) | *PRESCRIBER SIGNATURE (dispense as written)*

PRINT NAME (FIRST AND LAST) | *DATE*