

Rituximab (Rituxan, Truxima, Ruxience)



Provider Order Form rev. 10/4/2021

PATIENT INFORMATION

Date:	Patient Name:	DOB:
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Next Due Date (if applicable):	

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

- Hepatitis B status and date (Please provide results)

- Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

PRE-MEDICATION ORDERS

The following are manufacturer recommended premedication regimens:

- acetaminophen (Tylenol) 500mg / 650mg / 1000mg PO
- methylprednisolone (Solu-Medrol) 40mg / 125mg IV
- diphenhydramine (Benadryl) 25mg / 50mg PO / IV

ADDITIONAL PRE-MEDICATION ORDERS

- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- Other: _____
Dose: _____ Route: _____
Frequency: _____

SPECIAL INSTRUCTIONS

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- CRP at each dose every _____
- Other: _____

THERAPY ADMINISTRATION

Please check preferred product:

- Rituximab (Rituxan) Rituximab-abbs (Truxima)
- Rituximab-pvvr (Ruxience)
- Mix in 0.9% sodium chloride or D5W to final concentration of 1-4mg/ml
 - Dose: 1000mg / _____mg
 - Mix in: 500ml / 250ml
 - Frequency: On Series Day 0 and Series Day 14; repeat series every 24 weeks
 Other: _____
 - Infusion rate: First infusion in series: 50mg/hr, increasing every 30 minutes by 50mg/hr to maximum of 400mg/hr
 - Subsequent infusion in series: 100mg/hr, increasing every 30 minutes by 100mg/hr to maximum of 400mg
- Flush with 0.9% sodium chloride at the completion of infusion
- Monitor patient for 30 minutes post infusion
- Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

Pre-medicate patients with an antihistamine and acetaminophen prior to dosing. For RA and PV patients, methylprednisolone 100 mg intravenously or its equivalent is recommended 30 minutes prior to each infusion. Screen all patients for HBV infection by measuring HBsAg and anti-HBc before initiating treatment with RITUXAN. For patients who show evidence of prior hepatitis B infection (HBsAg positive [regardless of antibody status] or HBsAg negative but anti-HBc positive), consult with physicians with expertise in managing hepatitis B regarding monitoring and consideration for HBV antiviral therapy before and/or during RITUXAN treatment.

Provider Name (Print) _____ Provider Signature _____ Date _____

Email ivxintake@ivxhealth.com or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

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|---|---|---|---|--|
| <input type="checkbox"/> BAY AREA: 844-899-0275 | <input type="checkbox"/> COLUMBUS: 844-627-2675 | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> WEST TN: 888-615-1445 |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> HARRISBURG: 844-859-4235 | <input type="checkbox"/> KANSAS CITY: 844-900-1292 | <input type="checkbox"/> TAMPA: 844-946-0849 | <input type="checkbox"/> MIDDLE TN: 888-615-1445 |
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