Rituximab (Rituxan, Truxima, Ruxience)

IVX HEALTH

Provider Order Form *rev. 10/12/2022*

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ 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)

☑ Hepatitis B status and date (Please provide results)

_____

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: _____

LABORATORY ORDERS

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

THERAPY ADMINISTRATION

Many payors require patients start therapy with a rituximab biosimilar. Choose ONE of these two options:

☐ 1. Infuse rituximab (Rituxan) OR rituximab biosimilar as required by patient's insurance.
☐ 2. Infuse this rituximab product (subject to prior authorization):

_____

(Products include: Rituxan, Truxima, and Ruxience)

☑ Mix 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 infusion completion

☑ Monitor patient for 30 minutes post infusion
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____ (if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

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**

FAX NUMBERS

☐ CONNECTICUT: 860-955-1532	☐ HARRISBURG: 844-859-4235	☐ PALM BEACH: 561-768-9044	☐ TAMPA: 844-946-0849
☐ CHICAGO: 312-253-7244	☐ INDIANAPOLIS: 844-983-2028	☐ PHILADELPHIA: 844-820-9641	☐ WEST TN/AR: 888-615-1445
☐ BAY AREA: 844-889-0275	☐ COLUMBUS: 844-627-2675	☐ JACKSONVILLE: 904-212-2338	☐ RALEIGH: 919-287-2551	☐ MIDDLE TN: 888-615-1445
☐ CHARLOTTE: 336-663-0143	☐ DAYTONA: 386-259-6096	☐ KANSAS CITY: 844-900-1292	☐ SARASOTA: 941-870-6550	☐ EAST TN: 615-425-7427
☐ CINCINNATI: 844-946-0868	☐ FT. LAUDERDALE: 754-946-2052	☐ ORLANDO: 844-946-0867	☐ SOUTHWEST FL: 813-283-9144	