Local Infusion

MYLOCALINFUSION.COM

RITUXIMAB (AND BIOSIMILAR) ORDER FORM

❑ Rituximab (Rituxan) ❑ Rituximab-abbs (Truxima) ❑ Rituximab-pvvr (Ruxience) ❑ Rituximab-arrx (Riabni)

❑ **Dispense As Written (DAW)**

Will substitute for biosimilar or reference product based on insurance and availability

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments:_____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Rheumatoid Arthritis, ICD 10: M05.___ or M06.___

❑ Granulomatosis with Polyangiitis, ICD 10: M31.___

❑ Microscopic Polyangiitis, ICD 10: M31.7

❑ Pemphigus Vulgaris, ICD 10: L10.0

❑ Other:_____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION

Recommendations per PI are selected, these will be given to patient unless otherwise specified.

☑ Methylprednisolone (Solu-Medrol) 125mg IVP

☑ Benadryl 25mg PO

☑ Famotidine 20mg IV

☑ Acetaminophen (Tylenol) 500mg PO

❑ Cetirizine (Zyrtec) 10mg PO

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Rituximab	❑ 500 mg ❑ 1,000 mg ❑ 375 mg/m2	IV	❑ Day 0 and 14 x1 course ❑ Day 0 and 14, then repeat Day 0 and 14 every 6 months ❑ Day 0, 7, 14, and 21 x1 course ❑ Other _____

LABS / SPECIAL INSTRUCTIONS