Rituximab

Order Form
Rev. 10/12/2023

Phone: (833) 394-0600
Fax: (833) 996-4888

PATIENT INFORMATION **Referral Status:** ○ New Referral ○ Updated Order ○ Order Renewal

Date: Patient Name: DOB:

Allergies: Weight (kg): Height (cm):

ICD-10 Code(s) & Description *(required)*:

□ *(required)* The patient's demographics, insurance, lab results, meds and recent visit notes were sent to IA.

The patient has an existing prior authorization: ○ Yes *(please fax IA a copy)* ○ No *(IA will process for you)*

PRESCRIBING OFFICE

Contact Name: Contact Phone Number:

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

CLINICAL HISTORY

In the past year, what medications for the above diagnosis has the patient tried and failed?

Drug & Dose	Dates of Use	Drug & Dose	Dates of Use

Will rituximab be given in combination with methotrexate? ○ Yes ○ No

Hepatitis B Virus Screening is required before first dose: □ Copy Attached

Result Date: ____________ Result *(check one)*: ○ Positive ○ Negative

LAB ORDERS

Collect: □ BMP □ CMP □ CBC w/ diff □ CBC w/o diff □ CBC w/ man diff □ CRP □ ESR □ ________

Lab Frequency: ○ EVERY infusion ○ Every OTHER infusion ○ _____________

PRE-MEDICATION ORDERS

○ Diphenhydramine ○ PO or ○ IV □ 25mg or □ 50mg **OR** ○ Cetirizine 10 mg PO

○ Acetaminophen PO ______ mg

○ Methylprednisolone IV Push ______ mg **OR** ○ Hydrocortisone IV Push ______ mg

THERAPY ADMINISTRATION

Rituximab IV:

○ IA pharmacist to select product (chosen based on patient's insurance coverage and availability), **OR**

○ Select a product: □ Rituxan (rituximab) □ Ruxience (rituximab-pvvr) □ Truxima (rituximab-abbs)

Dose: _______ mg

Frequency: ____

Date of last infusion if not at IA: ___________ RX Expiration Date: ___________

Additional Notes from Referring Office:

Provider Name (Print) **Provider Signature** **Date**