



Rituximab Prescriber Order Form

Please Fax completed form with patient's demographics, Clinical notes, and recent labs to (855) 644-3687 or Email: Referrals@sandshealth.com

PATIENT

Patient Name: _____ Male Female SS#: _____ DOB: _____
 Address: _____ City, State, Zip: _____
 Primary Phone: _____ Home Cell Work Alternate Phone: _____ Home Cell Work
 Email: _____
 Allergies: _____

Clinical Information

Primary Diagnosis Description: _____ ICD-10 Code: _____
 Is this the first dose? Yes – date of first dose: _____
 No – date of next dose due: _____ Hepatitis B Status: _____ Titer Date: _____
 Positive Negative
 TB Status: PPD (negative) – date: _____ Active TB
 Last chest x-ray – date: _____ Unknown
 Past positive TB infection, course taken: _____

Rituximab Prescription

Medication	DOSE	ROUTE	FREQUENCY
<input type="checkbox"/> Rituxan® (Rituximab)	<input type="checkbox"/> 500 mg	IV	<input type="checkbox"/> Day 0 and 14 x1 course
<input type="checkbox"/> Ruxience™ (rituximab-pvvr)	<input type="checkbox"/> 1,000 mg		<input type="checkbox"/> Day 0 and 14, Repeat in 6 months
<input type="checkbox"/> Riabni (rituximab-arrx)	<input type="checkbox"/> 375 mg/m ²		<input type="checkbox"/> Day 0, 7, 14, and 21 x 1 course
<input type="checkbox"/> Truxima® (Rituximab-abbs)			<input type="checkbox"/> Other _____
<input type="checkbox"/> No Preference	Dose will be rounded to closest 100 mg vial.		

Ancillary Orders (Refill PRN X1 year)

Anaphylaxis Kit

Dosage: •Give Diphenhydramine capsule (s) 25 mg to 50 mg PO as needed #4 capsules
 •Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN. #2 vials
 •Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement. #1 vial
 •Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours
 PRN headache rated > 5 on pain scale.

Pre- Medication Orders

Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may decline.
 Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may decline.
 Loratadine 10 mg PO 30 min before infusion. Patient may decline.
 Methylprednisolone Succinate _____ mg IV push 20 minutes prior to infusion.
 Other: _____

IV Flush Orders

Peripheral: NS 3-5 mL pre-/post-use.
 Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

No labs ordered at this time.
 Other: _____

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____

Date: _____

Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact:

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