RITUXIMAB

(Rituxan or Biosimilars)

Order Form

Outpatient Infusion

Patient Name	
DOB	
Address	
Phone	

Order Status	☐ New Order	☐ Renewal	☐ Dose or Frequency Change

Allergies:	**Weight:** **Height:** **BSA:**

Diagnosis:
Diagnosis Code:

Required Information	Negative Quantiferon TB, T-spot or chest x-ray (no active disease)	Date:
	Diagnostic Hepatitis B panel	Date:
	Coccidioides Screen/Panel	Date:
	CBC and CMP	Date:

Required Documentation

- H&P or progress note supporting diagnosis
- Medication history
- Recent labs (as above) and/or diagnostic test results

Labs	☐ Hepatic Function panel every 3 months	☐ Other:

Pre-Medications

☐ Diphenhydramine	○ PO	○ 25 mg	☐ Acetaminophen	○ 325 mg
	○ IV	○ 50 mg		○ 650 mg
☐ Other:				

Medication Order

☐ **Rituxan (rituximab)**	☐ 375 mg/ m^2 IV	☐ Every _____ weeks for _____ doses
☐ **Riabni (rituximab-arrx)**	☐ 500 mg IV (flat dose)	☐ Every _____ months for _____ doses
☐ **Ruxience (rituximab-pvvr)**	☐ 1000 mg IV (flat dose)	☐ Other:
☐ **Truxima (rituximab-abbs)**	☐ Other:	
	Dose will be rounded up to nearest 100 mg	

Rituxan has several biosimilars. Certain payors may require use of a specific biosimilar. Please select allowed alternative if Rituxan is not covered by payor. If more than one, note preference.

☐ Alternative(s):

Infusion Reaction Medications

Hypersensitivity Reaction Protocol will be utilized unless otherwise specified

Provider (print name):	Date:
Provider Signature:	NPI:
Office Phone:	Office Fax: