

# RITUXIMAB (AND BIOSIMILAR) ORDER FORM

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- Rituximab (Rituxan)
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- Rituximab-abbs (Truxima)
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- Rituximab-pvvr (Ruxience)
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- Rituximab-arxx (Riabni)
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- 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)

- |   |  |
|---|--|
| <input type="checkbox"/> Rheumatoid Arthritis, ICD-10: _____                        | <input type="checkbox"/> Systemic Lupus Erythematosus, ICD-10: M32.9 |
| <input type="checkbox"/> Granulomatosis with Polyangiitis, ICD-10: M31. _____       | <input type="checkbox"/> Pemphigus Vulgaris, ICD-10: L10.0           |
| <input type="checkbox"/> Neuromyelitis Optica Spectrum Disorder, ICD-10: G36. _____ | <input type="checkbox"/> Other: _____ ICD-10: _____                  |

## 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:

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

## PRE-MEDICATION

These will be given to patient unless otherwise specified.

Methylprednisolone  
(Solu-Medrol) 125mg IVP

Benadryl 25mg PO

Acetaminophen (Tylenol) 500mg PO

Famotidine 20mg IV    **or**     Cetirizine (Zyrtec) 10mg PO

Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

## MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Rituximab	<input type="checkbox"/> 500 mg <input type="checkbox"/> 1,000 mg <input type="checkbox"/> 375 mg/m2	IV	<input type="checkbox"/> Day 0 and 14 x1 course <input type="checkbox"/> Day 0 and 14, Repeat in 6 months <input type="checkbox"/> Day 0, 7, 14, and 21 x1 course <input type="checkbox"/> Other _____

## OTHER NOTES

Order valid for 1 year from date of signature unless otherwise specified here: \_\_\_\_\_