

Rituximab (Rituxan®) or Biosimilar

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVe Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

Patient Name: _____ Patient Address: _____ Patient Phone Number: _____ Date of Birth: ____/____/____ Weight: ____ kg Height: ____ cm Allergies: _____	Primary Insurance: _____ Member ID: _____ Secondary Insurance: _____ Member ID: _____
<p style="text-align: center;">Diagnosis</p> Diagnosis Code (ICD-10): _____ Indication: _____ Target start date: _____	<p style="text-align: center;">Labs</p> <input type="checkbox"/> CBC w/ diff (specify frequency): _____ <input type="checkbox"/> Other: _____
Note to provider: Viral hepatitis B screening required prior to therapy initiation. Additional screening for hepatitis C, HIV, and TB may be warranted.	
Hold and Notify Provider: ANC below 1.5, Plt below 75K; signs/symptoms of active infection.	
Rituximab (Or Biosimilar) <input type="checkbox"/> Pharmacy to Select <input type="checkbox"/> Truxima (rituximab-abbs) <input type="checkbox"/> Ruxience (rituximab-pvvr) <input type="checkbox"/> Rituxan (rituximab) <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> Dose <input type="checkbox"/> 1000 mg IVPB <input type="checkbox"/> 375 mg/m² IVPB <input type="checkbox"/> 500 mg IVPB <input type="checkbox"/> Other: _____ </div> <div style="width: 45%;"> Frequency <input type="checkbox"/> Day 1 and 15, <input type="checkbox"/> Repeating every 6 months <input type="checkbox"/> Weekly for ____ weeks <input type="checkbox"/> Once <input type="checkbox"/> Other: _____ </div> </div> <p style="text-align: right; margin-top: 20px;">Note: interval to be no less than 20 weeks from day 1 dose of previous cycle</p>	

An Outpatient Department of Trinity Health Oakland
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Pre-Medications and Pre-Protocol (ordered at physician discretion)	<input checked="" type="checkbox"/> Acetaminophen 650 mg PO once <input type="checkbox"/> Loratadine 10 mg PO once <input checked="" type="checkbox"/> Diphenhydramine once <input checked="" type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> PO <input checked="" type="checkbox"/> IV <input type="checkbox"/> Famotidine 20 mg IV once <input type="checkbox"/> Hydrocortisone 100 mg IV once <input checked="" type="checkbox"/> Methylprednisolone 100 mg IVP once <input type="checkbox"/> Other: _____	Hydration <input type="checkbox"/> LR <input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> Other _____ mL at _____ mL/hr <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> Following
Flushing Protocol (pre and post medication)	<input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL as needed for line care	<input type="checkbox"/> Heparin _____ Units/mL _____ mL as needed for line care
Hypersensitivity Panel Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary	<ul style="list-style-type: none"> • Sodium chloride 0.9% bolus 500 mL once as needed for hypotensive management (SBP <90mmHg) • Acetaminophen 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping • Albuterol 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses • Albuterol HFA inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea • Epinephrine injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses • Famotidine injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Diphenhydramine injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom • Diphenhydramine injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Hydrocortisone sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure 	
<div> <div> Provider Name: _____ </div> <div> Provider Signature: _____ </div> </div> <div> <div> Attending Physician Name: _____ </div> <div> Provider NPI: _____ </div> </div> <div> <div> Office Phone Number: _____ </div> <div> Office Fax Number: _____ </div> </div> <p><i>(If ordering provider is an advanced practice practitioner)</i> <i>Note: This order is valid for 12 months from date of physician signature.</i></p>		