ArrIVe INFUSION THERAPY

An Outpatient Department of Trinity Health Oakland
9400 Village Place Blvd, Brighton, MI 48116-2084
Phone: 810-844-7373
Fax: 810-844-7366

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:** _____
Diagnosis Diagnosis Code (ICD-10): _____ Indication: _____ Target start date: _____	**Labs** ☐ CBC w/ diff (specify frequency): _____ ☐ 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)

☐ Pharmacy to Select
☐ Truxima (rituximab-abbs)
☐ Ruxience (rituximab-pvvr)
☐ Rituxan (rituximab)

Dose
☐ 1000 mg IVPB
☐ 375 mg/m^2 IVPB
☐ 500 mg IVPB
☐ Other: _____

Frequency
☐ Day 1 and 15, ☐ Repeating every 6 months
☐ Weekly for _____ weeks
☐ Once
☐ Other: _____

Note: interval to be no less than 20 weeks from day 1 dose of previous cycle

Reviewed/Updated January 2025

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Pre-Medications and Pre-Protocol (ordered at physician discretion)	☑ Acetaminophen 650 mg PO once ☐ Loratadine 10 mg PO once ☑ Diphenhydramine once ☑ 25 mg ☐ 50 mg ☐ PO ☑ IV ☐ Famotidine 20 mg IV once ☐ Hydrocortisone 100 mg IV once ☑ Methylprednisolone 100 mg IVP once ☐ Other: _____	**Hydration** ☐ LR ☐ Sodium Chloride 0.9% ☐ Other _____ _____ mL at _____mL/hr ☐ Before ☐ During ☐ Following
Flushing Protocol *as needed for line care*	☐ **Sodium Chloride 0.9%** ☐ 5 mL ☐ 10 mL	☐ **Heparin 100 Units/mL** ☐ 5 mL ☐ 10 mL
Hypersensitivity Panel Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary	• **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	

Provider Name: _____ Provider Signature: _____

Attending Physician Name: _____ Provider NPI: _____

Office Phone Number: _____ Office Fax Number: _____

(If ordering provider is an advanced practice practitioner)
Note: This order is valid for 12 months from date of physician signature.

Submit

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