

Rituximab Referral Form



REQUIRED INFORMATION

- ☐ This signed order form from the provider
- ☐ Patient demographics and insurance information
- ☐ Clinical/Progress Notes, Labs (including CBC, Hep B pabel—HbsAg, anti-HBc, quantitative Immunoglobulin—IgM, IgG, and IgA, negative TB Gold, Anti-HCV antibody) and Tests supporting primary diagnosis (ICD-10 below)
- ☐ Documentation of any tried and failed therapies

Patient Name:	DOB:	Weight:
Allergies:	Patient Phone:	
Diagnosis: ☐ Systemic Lupus Erythematosus (ICD-10 _____) ☐ Rheumatoid Arthritis (ICD-10 _____) ☐ Juvenile Idiopathic Arthritis (ICD-10 _____) ☐ Psoriatic Arthritis (ICD-10 _____) ☐ Other (ICD-10 _____)		
☐ Infuse rituximab OR rituximab biosimilar as required by patient's insurance (Rituxan, Ruxience, Truxima) ☐ Do not substitute. Infuse the following brand: _____ Dose: ☐ 1000 mg IV ☐ 500 mg IV ☐ 375 mg/m ² IV ☐ Other: _____ Frequency: ☐ Day 1 and Day 15 ☐ Every 24 weeks ☐ One time dose ☐ Other: _____ Refill: ☐ PRN x 1 year OR _____ times Protocol Pre-Medication Orders (optional): ☐ Acetaminophen 650 mg PO OR ☐ Acetaminophen 1000 mg PO ☐ Diphenhydramine ☐ 25 mg ☐ 50 mg ☐ PO ☐ IVSP Additional Pre-Medication Orders (optional): ☐ Methylprednisolone SS 125 mg IVSP ☐ Other: _____		
Required routine labs to be drawn by ☐ Infusion Center ☐ Referring Physician Labs: _____ Frequency: _____		
Supply Orders: ☐ Pharmacy to provide all supplies needed to complete therapy as prescribed ☐ May use Burnham's Vital Care flush and catheter maintenance protocol		
Nursing Orders: ☐ Pharmacy to provide nursing services, including vascular access, administration, and line care ☐ May use Burnham's Vital Care anaphylaxis protocol		
Additional Instructions: 		
Practitioner Name:	Practitioner Signature:	Date:
Practitioner Address:		

ALABAMA

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MISSISSIPPI

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