Rituximab Referral Form

REQUIRED INFORMATION

☐ Provider signature (see below)
☐ Patient demographics/insurance
☐ H&P, progress notes, pertinent labs (TB, Hep B screen/surface antigen/core antibody, immunologlobulin levels) and diagnostics to supporting ICD-10
☐ All tried/failed therapies

Patient Name:	**DOB:**	**Weight:**
Allergies:	**Patient Phone:**	

Diagnosis:

☐ Systemic Lupus Erythematous (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: