RITUXAN(rituximab)

☐ New Prescription/Referral
☐ Prescription Refill

# of Refills: ☐

Rx:

Patient Name: **Patient Weight:** kg **DOB:**

RITUXAN:

- ☐ Rituxan 1000mg x 2 doses via IV separated by 2 weeks
- ☐ Rituxan 500mg x 2 doses via IV separated by 2 weeks
- ☐ Repeat after 6 months.
- ☐ Initial Infusion: 50mg/hr, increase rate by 50mg/hr every 30 mins until max infusion rate of 400mg/hr
- ☐ Subsequent Infusions: 100mg/hr, increase rate by 100mg/hr every 30 mins until max infusion rate of 400mg/hr

Other Orders:

☐ OK to substitute with approved Biosimilars (Ruxience, Riabni, Truxima)
Please provide detailed order below.

Pre-Medication: (30 mins prior)

- ☐ Solumedrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Others:
- ☐ Tylenol _____mg PO
  - ☐ 650mg ☐ 975mg
- ☐ Benadryl _____mg
  - ☐ 25mg ☐ 50mg
  - ☐ IV ☐ PO

ANA Kit Protocol:

- ☐ OK to use

Dx:

- ☐ Rheumatoid Arthritis (M05.79)
- ☐ Others:

NPI#:

Physician Signature **Date: (Valid for 1 year)**

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name: **CLINIC:**

Contact Information: **Phone:** **Email:**
Fax: **Other:**

Office Mailing Address:

Please include the following

- ☐ Patient demographics
- ☐ Insurance attached
- ☐ Diagnosis (supporting)
- ☐ History and Physical
- ☐ Lab Results
- ☐ Clinical progress notes
- ☐ Medication List
- ☐ Other Test Results
- ☐ Hep B Surface Antigen
- ☐ Hep B Core
- ☐ CBC w/platelet

If Hepatitis B results are positive - please provide documentation of medical clearance