Rituximab Order Form (rituximab)

Fax To: 503-540-3105

PATIENT INFORMATION

Patient Name: ________________________________ DOB: __________ Phone: ______________ Sex: ☐ M ☐ F Ht:_____ Wt: _____ ☐ lbs ☐ kg

Primary Language: ____________________ Allergies: ____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

☐ M05. _______ Rheumatoid Arthritis w/Rheumatoid Factor
☐ M06. _______ Rheumatoid Arthritis w/o Rheumatoid Factor
☐ M31.30 Granulomatosis w/Polyangiitis (Wegener's Granulomatosis GPA)
☐ M31.7 Microscopic Polyangiitis
☐ Other: ____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, labs, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy

PRESCRIPTION

Pre-Medications

☐ Acetaminophen: 650 mg PO
☐ Cetirizine 10 mg PO
☐ Dexamethasone: ______ mg IV
☐ Diphenhydramine: 25 mg PO
☐ Diphenhydramine: 25 mg IV
☐ Other: ________________________________

☐ Acetaminophen: _____ mg PO
☐ Famotidine: _____ mg IV
☐ Loratadine 10 mg PO
☐ Methylprednisolone: _____ mg IV
☐ Ondansetron 4 mg IV

Lab Orders

☐ CBC w/diff: every ________ ☐ weeks ☐ month
☐ CMP: every __________ ☐ weeks ☐ month
☐ Other: _______________ ☐ weeks ☐ month

Drug

☐ Rituximab **OR** Biosimilar as dictated by patient's insurance*

***Oregon Specialty Infusion will determine appropriate product based upon benefit investigation**

OR

☐ Rituximab product ____________________________ (DO NOT SUBSTITUE)

Adverse Events: In the event of an adverse reaction occurring at Oregon Specialty Infusion clinic, OSI will utilize their adverse reactions protocol

Loading Dose (SELECT ONE)

☐ **IV:** Infuse 500 mg at weeks 0 and 2
☐ **IV**: infuse 1000 mg at weeks 0 and 2
☐ **IV:** Infuse _________ mg at weeks 0 and 2

Maintenance Dose (SELECT ONE)

☐ **IV:** Infuse _______ mg Single Dose every _________ ☐ weeks ☐ months x 1 year
☐ **IV:** Infuse _______ mg initial dose at Day 1 followed by 2nd dose on Day 15, then repeat cycle every ________ months x 1 year
☐ **IV:** Infuse _______ mg every week for 4 weeks total, then repeat cycle every _________ months x 1 year
☐ **IV:** Other frequency ____ x 1 year

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No
If yes, please note therapy and last dose: ____

PRESCRIBING INFORMATION

Prescriber Name: ____ Signature: ____

Date: _______________ NPI #__________________________________ Specialty: ____

Office phone #: ____ Office Fax #: ____

Prescription Valid for One Year