SandsRx Pharmacy

Phone: (844) 598-2557 Fax: (888) 388-1309

Rituximab Prescriber Order Form

Please Fax completed form with patient's demographics,Clinical notes, and recent labs to (888) 388-1309

PATIENT

Patient Name: _____ ❑ Male ❑ Female **SS#:** _____ **DOB:** _____

Address: _____ **City, State, Zip:** _____

Primary Phone: _____ ❑ Home ❑ Cell ❑ Work **Alternate Phone:** _____ ❑ Home ❑ Cell ❑ Work

Email: _____

Allergies: _____

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Is this the first dose?	☐ Yes – date of first dose: ☐ No – date of next dose due:	**Hepatitis B Status:**	Titer Date: ☐ Positive ☐ Negative

TB Status:	☐ PPD (negative) – date: ☐ Last chest x-ray – date: ☐ Past positive TB infection, course taken:	☐ Active TB ☐ Unknown

Rituximab prescription

☐ **Rituximab (Rituxan®)** ☐ **Ruxience™ (rituximab-pvvr)** ☐ **Riabni (rituximab-arrx) or** ☐ **Rituximab-abbs (Truxima®)**

- ☐ Infuse 375 mg/m2 IV once weekly for _____ doses.
- ☐ Infuse 375 mg/m2 IV on Day 1 of each chemotherapy cycle for up to _____ infusions.
- ☐ Infuse 1000 mg IV on Week 0 and Week 2. Repeat every 6 months
- ☐ Other:

Dose will be rounded to closest 100 mg vial.

Ancillary Orders

Anaphylaxis Kit

If this is a 1st infusion dose, would you like SandsRx Pharmacy to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

Dosage:
- Give Diphenhydramine capsule (s) 25 mg to 50 mg PO as needed **#4 capsules**
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN. **#2 vials**
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement. **#1 vial**
- Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

Pre- Medication Orders

- ☐ Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may decline.
- ☐ Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may decline.
- ☐ Loratadine 10 mg PO 30 min before infusion. Patient may decline.
- ☐ Methylprednisolone Succinate _____ mg IV push 20 minutes prior to infusion.
- ☐ Other: _____

IV Flush Orders

- ☐ Peripheral: NS 3-5 mL pre-/post-use.
- ☐ Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

- ☐ No labs ordered at this time.
- ☐ Other: _____

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: **Date:**

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State: **Zip:**	**Office Contact:**	

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