



Rituximab (Rituxan) Patient Referral Form

Admissions Fax # 844-878-6917

Admissions Phone # 855-WE-R-RARE (855-937-7273)

Patient Demographics Information

Patient Name		SSN#	DOB
Patient Address			
Primary Phone	Cellular Phone	Work Phone	
Emergency Contact Name, Relationship		Emergency Contact Phone Number	

Additional Documentation Needed

- Copy of insurance cards
- Patient face sheet w/demographics
- History and Physical
- Screening for HBV infection
- CBC w/diff, BMP, & CMP
- Recent vitals including blood pressure

Patient Insurance Information

Insurance Plan #1	Insurance Plan #2		
Plan Address	Plan Address		
Plan Phone & Fax Numbers	Plan Phone & Fax Numbers		
Subscriber Name	DOB	Subscriber Name	DOB
Policy Number	Group ID	Policy Number	Group ID

Patient Clinical Information

Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (inches)	Weight (lbs)	Allergies (food/drug)
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Statement of Medical Necessity / Primary Diagnosis

ICD10:	Description of diagnosis:
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Medication Information / Prescription and Orders

Medication	Dose	Directions	Quantity / Refills
Rituxan	_____mg (rounded to the nearest vial size)	Infuse IV per manufacturer guidelines OR over _____ hours.	Dispense: 1 dose, + 12 months refill unless otherwise noted <input type="checkbox"/> Other
Date of last infusion:	IV every _____ week(s)	Titration rate according to package insert.	
Next dose due:		Number of doses patient has received:	

Premedications

- RN to start peripheral IV or use existing CVC. RN to administer catheter flushing 2-10mL IV ad needed for infusion and line maintenance.
 - 0.9% Sodium Chloride
 - Heparin 10 units/ml
 - Heparin 100 units/ml
 - 0.9% Sodium Chloride Sterile (port)
- Give premedication 30 minutes prior to infusion (generics will be dispensed)
 - Diphenhydramine: 25-50 mg po #QS
 - Methylprednisolone: 125 mg slow IV push over 5 minutes #QS
 - Acetaminophen: 325-650 mg po **OR** _____ mg po #QS
- EMLA cream (Lidocaine 2.5% and Prilocaine 2.5%) topically #QS: apply to IV site prior to access PRN for pain upon needle insertion.
- Sodium Chloride 0.9% 500 mL - 1000 mL IV #QS over 1-2 hours as tolerated daily PRN for hydration.
- RN to instruct patient to hydrate pre/post infusion.
- Other (Physician to specify):

Quantity/Refills

Dispense:
quantity #QS + PRN refills
unless otherwise noted
 Other

Labs:

Frequency of labs:

Adverse Reaction Orders

- In the event of an infusion reaction (ie: fever, chills, rigors, pruritis, hemodynamic changes) the following orders will be followed and physician will be notified.
- Mild reaction: Pause infusion for 10 minutes, resume infusion at a minimum 50% reduction in rate after symptoms have resolved.
 - Moderate reaction: Pause infusion, administer Diphenhydramine 25 mg IV; administer Sodium Chloride 0.9% 500ml IV bolus. If symptoms persist, administer remaining Diphenhydramine 25 mg IV. Administer Diphenhydramine IM if no IV access. Notify Pharmacist. #QS
 - Severe reaction (w/breathing problems): CALL 911, administer Epinephrine 0.3 mg IM; administer Diphenhydramine 50 mg IV x1 dose; administer Sodium Chloride 0.9% 500mL IV bolus. Administer Diphenhydramine IM if no IV access. #QS

Prescriber Information

Physician Name	Office Contact		
Practice Address	Practice Phone		
NPI#	License #	DEA#	
Physician Signature Required - Substitution Permitted	Date	Physician Signature Required - Dispense as Written	Date