Rituximab (Rituxan) Patient Referral Form

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 ☐M ☐F	Height (inches)	Weight (lbs)	Allergies (food/drug)

Statement of Medical Necessity / Primary Diagnosis

ICD10: Description of diagnosis:

Medication Information / Prescription and Orders

Medication	Dose	Directions	Quantity / Refills
Rituxan Date of last Infusion:	________ mg *(rounded to the nearest vial size)* IV every_______________week(s)	Infuse IV per manufacturer guidelines **OR** over ______________ hours. Titration rate according to package insert.	Dispense: 1 dose, + 12 months refill unless otherwise noted ☐ Other

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