HERITAGE BIOLOGICS

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	
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:	

Line Access

RN to start peripheral IV or use existing CVAD. RN to administer catheter flushing and medications per Heritage Biologics policy.

☐ Sodium Chloride 0.9% 10 mL Flush: Flush with 2-10 mL sodium choride 0.9% IV before and after medication administration or every 24 hours while IV access in place.

☐ Sodium Chloride 0.9% 10 mL STERILE Flush: Flush with 5-10 mL STERILE sodium chloride 0.9% IV as needed for port access.

☐ Heparin Lock 100U/mL 5 mL Flush: Lock with 5 mL heparin 100U/mL after each use or daily while port accessed.

Quantity/Refills

Dispense:

Quantity #QS + PRN refills unless otherwise noted

☐ Other

Premedications

☐ **Give premedication 30 minutes prior to infusion** *(generics will be dispensed)*

Diphenhydramine: ☐ 25-50 mg PO

Methylprednisolone: ☐ 125 mg slow IV push over 5 minutes

Acetaminophen: ☐ 325-650 mg PO **OR** ☐ _____ mg PO

☐ EMLA topical cream (Lidocaine 2.5% and Prilocaine 2.5%): apply to IV site prior to access PRN for pain upon needle insertion.

☐ Sodium Chloride 0.9% 500 mL - 1000 mL IV over 1-2 hours as tolerated daily PRN for hydration.

☑ RN to instruct patient to hydrate pre/post infusion.

☐ Other (Physician to specify):

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.

❁ 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.

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