Rituximab Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.

Fax completed form, insurance information and clinical documentation to 414-260-7368.

Patient Name: ____________________ Date of Birth: ____________________

Address: ____________________

Phone: ____________________ Height: __________ ☐ inches ☐ cm Weight: __________ ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description: ____________________ ICD-10 Code(s): __________

Is this the first dose? ☐ Yes - Date of first dose __________ ☐ No - Date of next dose __________

Hepatitis B Status: Titer Date: __________ ☐ Positive ☐ Negative

Rituximab Prescription

☐ Rituximab (Rituxan®) ☐ Ruxience™ (rituximab-pvvr) ☐ Riabni (rituximab-arrx) or ☐ Rituximab-abbs (Truxima®) or biosimilar based on the preferred brand per insurance coverage, refill as directed x 1 year

☐ 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.

☐ Other: ____________________

Dose will be rounded to closest 100 mg vial.

Ancillary Orders

Anaphylaxis Orders

☐ Treat per Froedtert Home and Specialty Infusion protocol.

Medication Orders

☐ Acetaminophen __________ mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may decline.

☐ Diphenhydramine __________ mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may decline.

☐ Methylprednisolone 100 mg IV over 15 to 60 min; 30 min prior to infusion..

☐ Other: ____________________

IV Access and Flush Orders: RN to access and monitor venous infusion line as indicated below:

☐ Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.

☐ Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab draw.

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 __________ Time __________

Prescriber Name ____________________ Phone __________ Fax __________

Address ____________________ NPI __________

City, State, Zip ____________________ Office Contact __________

Original - Medical Records

Froedtert Home and Specialty Infusion
N86 W12999 Nightingale Way
Menomonee Falls, WI 53051
262-532-5040