INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Rituximab *Rituxan & biosimilars*

- ☐ Rituximab (Rituxan)
- ☐ Rituximab-abbs (Truxima)
- ☐ Rituximab-pvvr (Ruxience)
- ☐ Rituximab-arrx (Riabni)
- ☐ Dispense as written (DAW) Will substitute for biosimilar or reference product based on insurance and availability unless DAW is checked.

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

- ☐ Rheumatoid Arthritis, ICD 10: M05._____ or M06._____
- ☐ Microscopic Polyangiitis, ICD 10: M31.7
- ☐ Granulomatosis with Polyangiitis, ICD 10: M31._____
- ☐ Pemphigus Vulgaris, ICD 10: L10.0
- ☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

- ☐ HBsAg (Hepatitis B surface antigen) & Anti-HBc (Hepatitis B core antibody, total or IgG)
- ☐ Demographics
- ☐ Labs and tests supporting diagnosis
- ☐ Office/progress notes

PRE-MEDICATION

Recommendations per PI are pre-selected; these will be given unless otherwise specified.

- ☑ Acetaminophen (Tylenol) 500 mg PO
- ☑ Famotidine 20 mg IV
- ☑ Methylprednisolone (Solu-Medrol) 125 mg IVP
- ☑ Diphenhydramine (Benadryl) 25 mg PO
- ☐ Cetirizine (Zyrtec) 10 mg PO
- ☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Rituximab	☐ 500 mg ☐ 1,000 mg ☐ 375 mg/m2	IV	☐ Day 0 and 14 x1 course ☐ Day 0 and 14, then repeat Day 0 and 14 every 6 months ☐ Day 0, 7, 14, and 21 x1 course ☐ Other: _____

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____