Rituximab (Rituxan, Ruxience)

Provider Order Form rev. 7/30/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Non-Hodgkin's Lymphoma: Chronic Lymphocytic Leukemia: Rheumatoid Arthritis:

Other: Description:

THERAPY ADMINISTRATION *(Select one)*

☐ Infuse rituximab (Rituxan) OR rituximab biosimilar as required by patient's insurance.

☐ Infuse this rituximab product (subject to prior authorization):

_____

DOSING

☐ Rituximab _____ mg IV

☐ Rituximab _____ mg/m2 x (Current BSA) _____ m2 = _____ mg *(Dose will be rounded up to 10% to nearest 100 mg per protocol unless specified below).*

☐ Dose rounding prohibited.

☑ Doses less than 500mg will go in final volume 250ml ml NS. Doses greater than 500mg will go in final volume 500 ml NS.

FREQUENCY

☐ Infuse on Day 0 and Day 14

☐ Infuse on Day 0, Day 7, Day 14, and Day 21

☐ Other: _____

☐ Repeat dosing in _____ weeks.

☐ Repeat dosing in _____ months.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every: _____

☐ CMP ☐ at each dose ☐ every: _____

☐ CRP ☐ at each dose ☐ every: _____

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Loratadine 10mg PO

☑ Required Tylenol 500mg PO

☐ Solumedrol 125mg IV ***(Required for diagnosis of RA)***

☑ Required Benadryl 25 mg PO

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Signs/symptoms of infection, surgical procedures, recent live vaccines, neurological or mood changes.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, biologic agent and steroids, BSA of affected skin (by indication)

Required Labs: Include negative Hepatitis B, CBC w/diff platelets, renal function, CRP, ESR, for RA: Rheumatoid Factor, CCP

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.