Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

Rituximab Order Form

Patient Name: _____ DOB:_____

Phone:_____ Address: _____

City: _____ State:_____ Zip:_____ Email: _____

Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ☐ Rheumatoid Arthritis ICD-10:_____
- ☐ Granulomatosis w/Polyangitis ICD-10:_____
- ☐ Other:_____ICD-10:_____
- ☐ Pemphigus Vulgaris ICD-10:_____
- ☐ Microscopic Polyangitis ICD-10:_____

ORDER FOR RITUXIMAB:

☐ **Infuse rituximab OR rituximab biosimilar** as required by patient's insurance determination x 1 year

(Preferred product to be determined after benefits investigation)

☐ Do not substitute: Continue to treat with the following rituximab product x 1 year

☐ Rituxan ☐ Ruxience ☐ Truxima ☐ Riabni

Frequency:

☐_____mg IV every 2 weeks for 2 doses, then repeat _____weeks **OR** _____ months x 1 YEAR

☐ Every 6 months x 1 YEAR

☐ Other Frequency: _____

PRE-MEDICATIONS:

- ☑ Acetaminophen 650mg PO
- ☑ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- ☑ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion
LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI:_____

Physician Signature: _____ Date:_____

Point of Contact: _____ Phone:_____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

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Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

☐ Signed provider orders (page 1)
☐ Patient demographic and insurance information
☐ Patient's current medication list
☐ Supporting recent clinical notes and H&P (to support primary diagnosis)
☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy:

- ☐ Has the patient had a documented contraindication/intolerance or failed trial of a glucocorticoids?
  - ☐ Yes OR ☐ No
- ☐ Does the patient have an intolerance or failed trial to a rituximab biosimilar?
  - ☐ Yes OR ☐ No
  - If yes, which drug(s)? _____

- ☐ If appliable: Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, or conventional therapy (i.e., MTX, leflunomide)?
  - ☐ Yes OR ☐ No
  - If yes, which drug(s)? _____

- ☐ If applicable: Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Enbrel, Stelara, Cimzia)?
  - ☐ Yes OR ☐ No
  - If yes, which drug(s)? _____

☐ If applicable - Last known biological therapy: _____ and last date received: _____.
If patient is switching to biologic therapies, please perform a wash-out period of _____ weeks prior to starting rituximab.
☐ Other medical necessity: _____

Additional REQUIRED Information:

☐ Include labs and/or test results to support diagnosis - please attach results
☐ CBC w/platelet
☐ Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) - please attach results

- ☐ Positive OR ☐ Negative

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