

RITUXIMAB (AND BIOSIMILAR) ORDER FORM

- Rituximab (Rituxan)
 Rituximab-abbs (Truxima)
 Rituximab-pvvr (Ruxience)
 Rituximab-arrx (Riabni)
 If insurance denies ordered drug **OK** to change to a suggested biosimilar above

PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Mobile Number: _____ Patient Weight: _____
 Allergies: _____

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 name): _____ Provider NPI: _____
 Signature: _____ Date: _____
 Contact Name: _____ Phone: _____ Fax: _____
 Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

- Demographics
 Labs and tests supporting diagnosis
 Office/progress notes

PRE-MEDICATION (Not typically indicated)

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

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Rituximab	<input type="checkbox"/> 500 mg <input type="checkbox"/> 1,000 mg <input type="checkbox"/> 375 mg/m2	<input type="checkbox"/> IV	<input type="checkbox"/> Day 0 and 14 x1 course <input type="checkbox"/> Day 0 and 14, Repeat in 6 months <input type="checkbox"/> Day 0, 7, 14, and 21 x1 course <input type="checkbox"/> Other _____

New Start Therapy
 Continuation of Therapy
 Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: CT: 203.433.0621
 ME: 207.407.7272
 NH: 603.217.5371
 NJ: 201.581.4521

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