Rituxan, Truxima, Ruxience (Rituximab)

Preferred Clinic Location

☐ **Harbor Health Park Bend Clinic**
2200 Park Bend Drive, Bldg 2, Suite 300, Austin, TX 78758
P: (855) 481-8375
F: (512) 233-2288

Patient Information

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

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

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

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

Supporting Documents/Information (Please provide all of the following)

- Patient insurance information
- Patient medication list
- Patients current weight and height
- Hepatitis B Status and date
- Most recent CBC results
- Patient has moderately to severely active rheumatoid arthritis or is currently taking methotrexate

Orders

NURSING

☑ Nursing care per Harbor Health Nursing Procedures and Harbor Health Adverse Reaction Management Protocol.

LABORATORY

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

PRE-MEDICATION

The following are manufacturer recommended premedication regimens to be given 30 minutes prior to each infusion:

☑ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☑ 1000mg PO
☑ methylprednisolone (Solu-Medrol) ☐ 40mg / ☑ 125mg IV
☑ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

ADDITIONAL PRE-MEDICATION

☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ Other: _____
Dose: _____ Route: _____ Frequency: _____

THERAPY

☑ **Rituximab** (Rituxan) or other rituximab product (as required by patient's health plan)

Many payors require patients start therapy with a rituximab biosimilar. Choose ONE of these two options:

☐ 1. Infuse rituximab (Rituxan) OR rituximab biosimilar as required by patient's insurance.
☐ 2. Infuse the following rituximab product: _____
(Products include: Rituxan, Truxima, and Ruxience)
☑ Mix 0.9% sodium chloride or D5W to final concentration of 1-4mg/ml
- Dose: ☐ 1000mg / ☐ _____mg
- Frequency: ☐ On Series Day 0 and Series Day 14; repeat series every 24 weeks
  ☐ On Day_____ and Day_____; repeat series every_____weeks
  ☐ _____times per week for _____weeks
  ☐ Other: _____

☑ Infusion rate: First infusion: 50mg/hr, increasing every 30 minutes by 50mg/hr to maximum of 400mg/hr
☑ Subsequent infusions: 100mg/hr, increasing every 30 minutes by 100mg/hr to maximum of 400mg
☑ Flush with 0.9% sodium chloride at infusion completion
☑ Monitor patient for 30 minutes post infusion

Provider Name (Print): Provider Signature: Date:

Harbor Health