SOMC Cancer Center & Infusion
Ph: (740) 356-7490
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Rituximab (Rituxan) Order Form

PATIENT & PRESCRIBER INFORMATION

Patient Name: ______________________________ DOB: ____________ Phone: (H) _________________ (C) _________________

Patient Address: ____

Ht.: _______ Wt.: _______ ☐lbs. ☐kg. Allergies: ____

Prescriber Name/Title: ________________________________ Address: ____

Phone: ______________________ Fax: ______________________ Prescriber NPI #: _____________________________________

REQUIRED: **Most Recent H&P, clinical notes, & medication list are required unless the patient is established with SOMC. Supporting clinical notes should include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

LAB RESULTS: Include Negative Hepatitis B within 3 years. History of Zoster Vaccination (if applicable)

DIAGNOSIS, CLINICAL INFORMATION, & PRESCRIPTION

Rituximab (Rituxan) or **Rituximab biosimilar**

☒ **May substitute mandated or preferred biosimilar as necessary.**

☒ **Infusion rates will follow manufacturer recommendations.**

☒ **In the event of an adverse reaction, line maintenance/flushes, or O2 are required, the SOMC AIC established protocols will be utilized.**

☒ **Monitor for any adverse events post administration for at least 30 minutes or until clinically stable.**

Pre-Treatment Medications: (Check all that apply) **To be administered 30 minutes prior to each administration.**

☐ Acetaminophen (Tylenol) 650 mg by mouth x 1 dose

☐ 25 mg / ☐ 50 mg Diphenhydramine (Benadryl) ☐ PO or ☐ IV x 1 dose

☐ Methylprednisolone (Solumedrol) 100 mg IVP x 1 dose

☐ Other (**Please Specify**) –____

AND

<u>**Diagnosis**</u> (Check all that apply)

☐ Rheumatoid Arthritis

<u>Dose</u>:

☐ **Rituximab (Rituxan) 1000 mg IV to be given on day(s) ______ and ______ for ______ treatments.**

☐ **Rituximab (Rituxan) 500 mg IV to be given on day(s) ______ and ______ for ______ treatments.**

OR

<u>**Diagnosis**</u>

☐ Other (**Please Specify**) –____

<u>Dose</u>:

☐ **Rituximab (Rituxan) 375 mg/m2**

☐ **Rituximab (Rituxan) 500 mg**

☐ **Rituximab (Rituxan) 1000 mg**

<u>Frequency</u>:

☐ **One time dose**

☐ **Day 0, repeat dose in 2 weeks, then repeat course every ___ weeks OR ___ months x ___ months**

☐ **Day 0, repeat dose once in 2 weeks**

☐ **Weekly x 4 weeks**

☐ **Every 6 months x 2**

☐ **Other ___________________________**
____

Additional order(s)____

Lab order(s)

☐ **CBC**	☐ **at each dose**	**or**	☐ **every ___________**
☐ **CBC w/ Diff**	☐ **at each dose**	**or**	☐ **every ___________**
☐ **CMP**	☐ **at each dose**	**or**	☐ **every ___________**

☐ **Other –** ____

PROVIDER:	**DATE:**	**TIME:**	**SIGNATURE:**

Southern Ohio Medical Center
Very Good things are happening here

RITUXIMAB

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