FLOMED INFUSION

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RITUXAN (rituximab)

PATIENT INFORMATION

Patient Name:_____ Date of Birth: _____ Phone: _____
Status: ☐ New to therapy ☐ Continuing ☐ Next Due Date (if applicable)

PROVIDER INFORMATION

Provider Name:_____ Provider NPI: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

Practice Name: _____

Practice Phone: _____ Fax: _____ Contact Person: _____

MEDICAL INFORMATION

Patient Weight: _____ Patient Height: _____ ICD-10 Code (required): _____ ICD-10 Description: _____

Known Allergies: _____

Required Labs: CBC w/Platelet, Hepatitis B antigen, Hepatitis B core total antibody

DETAILS NEEDED FOR AUTHORIZATION

• Proof of patient being concurrently treated with any other biologic: _____

RITUXAN (rituximab) ORDERS

☐ 375mg/m2 Rituxan
☐ 500mg Rituxan
☐ 1000mg Rituxan

Frequency:
☐ One Dose
☐ Day 0, repeat dose in 2 weeks
☐ Other: _____

Protocol Pre-Medication:
☐ Solu-Medrol 100 mg IV, Tylenol 1000mg PO, Benadryl 50mg PO/IV
☐ Other: _____

Additional Orders/Comments: _____

_____

ADULT RESCUE MANAGEMENT PROTOCOL

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

• Following standing reaction orders, including diphenhydramine, methylprednisolone, albuterol, and oxygen as needed.
• For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

REQUIRED STANDARD DOCUMENTATION NEEDED

• Patient demographics
• Patient medical insurance card, copied front and back
• Patient pharmacy card, copied front and back (if they have one)
• Most recent chart notes and if available, last history and physical. All relevant scans, tests and laboratory results.
• If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

PROVIDER AUTHORIZATION

Provider's Signature: _____ Print Name: _____ Date: _____