Rituximab (Rituxan, Truxima, Ruxience)

Provider Order Form *rev. 11/06/26*

arbor infusion

PATIENT INFORMATION

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

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐ NKDA Allergies:

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

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

• Hep B Panel: HBsAg, HBsAb (anti-HBs): If Hepatitis B results are positive, provide documentation of medical clearance

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐ M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified ☐ M05.79 RF-positive rheumatoid arthritis, multiple sites, without organ involvement

☐ M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites ☐ M06.89 Other specified rheumatoid arthritis, multiple sites

☐ M31.7 Microscopic Polyangiitis ☐ M31.30 GPA, without renal involvement ☐ M31.31 GPA, with renal involvement

☐ Other:

PRIMARY MEDICATION ORDER

Rituximab (Rituxan) OR rituximab biosimilar IV as required by patient's insurance. Dilute in 0.9% Sodium Chloride to achieve a final concentration of 1-4 mg/mL

- **First Infusion:** 50 mg/hr, increasing every 30 minutes by 50 mg/hr to maximum of 400 mg/hr
- **Subsequent infusions:** 100 mg/hr, increasing every 30 minutes by 100 mg/hr to maximum of 400 mg/hr
- Flush with 0.9% sodium chloride at infusion completion
- Refill for 12 months unless otherwise noted: _____

DOSE	FREQUENCY
☐ 500 mg	☐ Day 0 and Day 14, repeat series every _____ weeks
☐ 1,000 mg	☐ Once weekly for 4 weeks
☐ 375 mg/m2	☐ Once
	☐ Other: _____

NURSING

- Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: Recommendations per PI are selected, these will be given to patient unless otherwise specified.

☑ acetaminophen (Tylenol) ☑ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ famotidine (Pepcid) 20 mg IV

☑ diphenhydramine (Benadryl) ☑ 25mg / ☐ 50mg ☑ PO / ☐ IV

☑ methylprednisolone (Solu-Medrol) ☐ 40mg / ☑ 125mg IV

☐ Other: _____

Dose: _____ Route: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Other: _____

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐ Arbor Infusion Fishers (317) 981-1772

☐ Arbor Infusion Carmel (317) 981-1772