

Rituximab (Rituxan, Truxima, Ruxience)

Provider Order Form rev. 8/24/26



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), HBcAb (anti-HBc): 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

RECOMMENDED PRE-MEDICATION ORDERS

Note: The following are manufacturer recommended premedication regimens:

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

ADDITIONAL PRE-MEDICATION ORDERS

- ☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ famotidine (Pepcid) 20 mg 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