

RITUXIMAB (Rituxan, Truxima, Ruxience)

Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____

DOB: _____ Allergies: NKDA _____

Phone Number: _____

Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

Required Documentation

- Patient Demographics and Insurance Card Medication List Most recent labs
 Clinical/Progress Notes Supporting Dx Hep B Status Results


Primary Diagnosis

- ICD-10 Code (required): _____ Granulomatosis with Polyangiitis (GPA)
 Non-Hodgkin's Lymphoma (NHL) Microscopic Polyangiitis (MPA)
 Chronic Lymphocytic Leukemia (CLL) Pemphigus Vulgaris (PV)
 Rheumatoid Arthritis (RA) Other: _____

Pre-Medication

- Per violet health protocol: Acetaminophen 650 mg PO, Diphenhydramine 25 mg IV, Methylprednisolone 100 mg IV 30 minutes prior to infusion  Other: _____

Therapy Administration

- Rituxan OR Rituximab biosimilar may be used according to payer guidelines 
 IF you require a specific brand please indicate the brand required: _____

Medication Order:

- Rituximab 1000mg IV on day 1 and day 15, repeat course after 24 weeks from initial dose RN to flush and lock VAD/CVAD per violet health protocol (see violetinfusions.com/protocol for policy)
 Rituximab 375mg/m² (_____ mg) IV once weekly x 4 weeks Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy)
 Other: _____ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines.
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration.
 Other: Please fax alternative reaction orders, flush orders, or nursing administration orders if checking this box

Refills:

- x 1 year Other: _____

Lab Orders

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

Provider Information

Provider Name: _____ Office Contact Person: _____
 Referring Practice Name: _____ Phone Number: _____
 Referring Practice Address: _____ Fax Number: _____
 City, State, Zip: _____ Email: _____
 Provider NPI: _____
 Provider Signature: _____ Date: _____