VAIL HEALTH OUTPATIENT ORDERS

322 Beard Creek Rd | Edwards, CO 81632 | Ph: 970.569.7418 | Fax: 970.470.6675

Vail Health includes services of Vail Health Hospital

RiTUXmab (Rituxan, Ruxience, Truxima) Order Form

ATTACH DEMOGRAPHICS / COPY OF INSURANCE CARD, RECENT OFFICE VISIT NOTES AND HEPATITIS SCREEN

Patient Name:

DOB:

Allergies/Adverse Reactions:

ICD-10:

Diagnosis:

Weight (kg): _____

☐ **New Start**

☐ **Continuation of therapy:**
(date next treatment due: _____)

*****Results of hepatitis screen MUST be attached to initial order*****

Labs(to be drawn every visit unless otherwise specified):

☐ **CD20**

☐ **IgG**

☐ **CRP**

☐ **ESR**

Pre-Meds:

☐ **Acetaminophen 650 mg PO**

☐ **Loratadine 10mg PO**

☐ **Diphenhydramine 25 mg IV**

☐ **Methylprednisolone 100 mg IV**

Medication: RiTUXimab IV

☐ **Truxima (preferred) or okay to sub insurance preferred biosimilar _____(Shaw staff to complete)**

☐ **Dispense as written (drug) _____**

Rationale: _____

Dose(check one):

☐ **1000 mg Day 1 and Day 15**

☐ **1000 mg on Day 1**

☐ **500 mg on Day 1**

☐ **500 mg Day 1 and Day 15**

☐ **375 mg/m2 once weekly for 4 weeks**

Frequency:

☐ **every 4 months**

☐ **Every 6 months**

Administration Rate: Titrate per PI and Vail Health Policy

Refills:

☐ **One time** ☐ **One year** ☐ **Other _____**

☒ **Treat hypersensitivity reaction per Vail Health Hypersensitivity Protocol**

Provider Signature: _____ **Date / Time: _____**

PRINTED PROVIDER NAME: _____ **Circle: MD / PA / NP**

Office Name: _____ **NPI: _____** **State License: _____**

Phone #: _____ **Fax #: _____**

PHO