EPSRx A CarePartners Pharmacy Company | CarePartners Specialty Infusion

Phone : 844-800-5377 Fax : 214-782-9155

RITUXAN (rituximab) Rx ENROLLMENT FORM

PATIENT INFORMATION

Patient Name:	Date of Birth:	Gender:
Home Phone:	Cell Phone:	Email:
Address:	City: State:	Zip:
Emergency Contact:	Emergency Phone:	

CLINICAL INFORMATION

Diagnosis (ICD-10) Code: _____

Patient Weight: _____ ☐ kg ☐ lbs

Patient Height: _____ ☐ cm ☐ in

Allergies: _____

REQUIRED DOCUMENTATION

- ☐ Insurance Card
- ☐ History & Physical
- ☐ Patient Demographics
- ☐ Current Medication List
- ☐ Hep B Surface Antigen (within 36 months)
- ☐ Hep B Core (if available)

PRESCRIBER INFORMATION

Prescriber Name: _____

DEA #: _____ NPI #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact Person: _____

Pharmacy to coordinate home health nursing visit and/or nursing training as necessary.

PRESCRIPTION INFORMATION

Dose and Directions	Refill
☐ Dilute Rituxan to a final concentration of _____mg/mL (range 1-4 mg/mL) with _____ mL of Sodium Chloride 0.9% • **First infusion:** Administer at an initial rate of 50mg/hr. Increase rate by 50mg/hr q 30 minutes to a maximum rate of 400mg/hr, as tolerated. • **Subsequent infusions:** Administer at an initial rate of 100mg/hr. Increase rate by 100mg/hr q 30 minutes to a maximum rate of 400mg/hr, as tolerated.	☐ 6 Months ☐ 12 Months ☐ Other: _____
• Check and record vital signs q 5 minutes for the first 15 minutes, q 15 minutes for the next hour, q 30 minutes for the next hour, and then hourly for the remainder of the infusion. • Stop infusion for fever (T>101.5; hypotension (↓ 30mm/Hg from baseline), chills, rigors, dizziness, dyspnea or early signs of bronchospasm. **(Notify MD. Keep vein open)** • After resolution of symptoms, infusion may be resumed at one-half of the previous rate and increased per above protocol. ☐ Other: _____	

REQUIRED FOR HOME INFUSION

RX to include diluents, needles, syringes, ancillary supplies, home medical equipment to administer infusion.

IV Access	**To be administered PERIPHERALLY, unless otherwise indicated.** ☐ PORT ☐ PICC
Flush Protocol for drug admin days only	• 0.9% NaCl: 1-10mL IV before/after infusion, or PRN for line patency/SASH. • Heparin 100 units/mL: 5mL IV (central) PRN for final flush.
Pre-Medications Please strikethrough if not required	☐ **Acetaminophen** ☐ 500mg ☐ 650mg ☐ 1,000mg **To be given by mouth 30 minutes prior to infusion.** ☐ **Diphenhydramine** ☐ 25mg ☐ 50mg ☐ PO ☐ IV **To be given 30 minutes prior to infusion.** ☐ **Methylprednisolone (Solu-Medrol)** ☐ 40mg ☐ 125mg IV **To be given intravenously 30 minutes prior to infusion.**
Anaphylaxis Protocol	**Mild Reaction Protocol:** ☐ Diphenhydramine 25mg IV, one time, for pruritus. *If symptoms worsen, see orders for moderate to severe reactions.* **Moderate Reaction Protocol:** ☐ Acetaminophen 650mg PO, one time, for pyrexia or rigors. ☐ Diphenhydramine 50mg IV, one time, for pruritis or urticaria ☐ Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms. *If symptoms worsen, see interventions for severe reactions.* **Severe Reaction Protocol: (Call 911 if initiated)** ☐ Diphenhydramine 50mg IV, one time, for respiratory symptoms, edema, or anaphylaxis. ☐ Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis. ☐ Sodium Chloride 0.9% 500mL IV over 30-60 minutes, one time, for cardiovascular symptoms ☐ Epinephrine 0.3mg/0.3mL IM into the mid-anterolateral aspect of the thigh for anaphylaxis. May repeat x1 in 5-15 minutes if symptoms are not resolved or worsen.
Additional Orders	

PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

☐ May Substitute/Product Selection Permitted/Substitution Permissible

Prescriber Signature _____ **Date** _____

☐ Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute

Prescriber Signature _____ **Date** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**"

NY & Iowa providers, please submit electronic prescription.