

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: _____

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.

REQUIRED DOCUMENTATION

Insurance Card Current Medication List

History & Physical Hep B Surface Antigen (within 36 months)

Patient Demographics Hep B Core (if available)

PRESCRIPTION INFORMATION

Dose and Directions	Refill
<input type="checkbox"/> Dilute Rituxan to a final concentration of _____ mg/mL (range 1-4 mg/mL) with _____ mL of Sodium Chloride 0.9% <ul style="list-style-type: none"> 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. <ul style="list-style-type: none"> 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. <input type="checkbox"/> Other: _____	<input type="checkbox"/> 6 Months <input type="checkbox"/> 12 Months <input type="checkbox"/> 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

<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 500mg	<input type="checkbox"/> 650mg	<input type="checkbox"/> 1,000mg	To be given by mouth 30 minutes prior to infusion.
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25mg	<input type="checkbox"/> 50mg	<input type="checkbox"/> PO <input type="checkbox"/> IV	To be given 30 minutes prior to infusion.
<input type="checkbox"/> Methylprednisolone (Solu-Medrol)	<input type="checkbox"/> 40mg	<input type="checkbox"/> 125mg	IV	To be given intravenously 30 minutes prior to infusion.

Anaphylaxis Protocol	Mild Reaction Protocol:	Severe Reaction Protocol: (Call 911 if initiated)
	<input type="checkbox"/> Diphenhydramine 25mg IV, one time, for pruritus. <i>If symptoms worsen, see orders for moderate to severe reactions.</i>	<input type="checkbox"/> Diphenhydramine 50mg IV, one time, for respiratory symptoms, edema, or anaphylaxis. <input type="checkbox"/> Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis. <input type="checkbox"/> Sodium Chloride 0.9% 500mL IV over 30-60 minutes, one time, for cardiovascular symptoms <input type="checkbox"/> Epinephrine 0.3mg/0.3mL IM into the mid-antrolateral aspect of the thigh for anaphylaxis. May repeat x1 in 5-15 minutes if symptoms are not resolved or worsen.
	Moderate Reaction Protocol: <input type="checkbox"/> Acetaminophen 650mg PO, one time, for pyrexia or rigors. <input type="checkbox"/> Diphenhydramine 50mg IV, one time, for pruritis or urticaria <input type="checkbox"/> Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms. <i>If symptoms worsen, see interventions for severe reactions.</i>	

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.

<input type="checkbox"/> May Substitute/Product Selection Permitted/Substitution Permissible	<input type="checkbox"/> Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute
Prescriber Signature _____	Prescriber Signature _____
Date _____	Date _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" NY & Iowa providers, please submit electronic prescription.

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