Premier Health
Rituximab Infusion Faxed Order Form

Patient Name _____ Date of Birth _____

Patient MRN# _____

Patient's Allergies_____

Ordering Physician_____Physician'sPhone/Fax#_____/_____

Patient's Hepatitis B Screening Completed: date_____ result_____

(Please note that Hepatitis B Core Antibody (total), Hepatitis B Surface Antibody Quantitative (total), Hepatitis B Surface Antigen Antibody must be done and with results completed prior to initiation of therapy)

Infusion Center Fax Numbers:

MVH Middletown: 513-974-5023
MVH South: 937-641-2676
MVH Troy: 937-440-4503
MVH North: 937-641-2378
MVH Greenville: 937-641-7205

PLEASE HAVE PATIENT BRING CURRENT MEDICATION LIST

Diagnosis:

- ☐ Rheumatoid arthritis (M06.9)
- ☐ Microscopic polyangiitis (M31.7)
- ☐ Immune thrombocytopenia (D69.3)
- ☐ Dermatomyositis (M33.13)
- ☐ Lupus nephritis (M32.14)
- ☐ Membranous nephropathy (N02.2)
- ☐ Multiple sclerosis (G35)
- ☐ Myasthenia gravis (G70.00)
- ☐ Neuromyelitis optica (G36.0)
- ☐ Thrombotic thrombocytopenia purpura (M31.19)
- ☐ Warm immune hemolytic anemia (D59.11)
- ☐ Other: _____

PHYSICIAN ORDERS

PREMEDICATIONS: (check those preferred)

☐ Acetaminophen 650 mg PO Once (prior to infusion)

☐ Diphenhydramine 50 mg PO Once (prior to infusion)

Suggested Premed for Rheumatoid and Neurologic indications

☐ Methylprednisolone 125 mg IVP Once (20 minutes prior to infusion)

RITUXIMAB:

☐ **Ruxience (rituximab-pvvr) (Preferred PH agent) (Q5119)**

☐ Truxima (rituximab-abbs) (Q5115)

☐ Riabni (rituximab-arrx) (Q5123)

☐ Rituxan (rituximab) (J9312)

DOSE: _____ mg/m^2 OR _____ mg (All doses will be rounded to the nearest 100 mg dose if dose falls within 10%) (Doses falling outside of 10% may not be rounded without a call to provider)

(Doses will be admixed 0.9% sodium chloride to a concentration of 4mg/mL)

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FREQUENCY:

☐ Once
☐ Every _____ weeks for _____doses
☐ Every 2 weeks for 2 doses, repeat cycle every _____ weeks (16-24)

ADMINISTRATION:

☐ Initial dose - Start at rate of 50 mg/hr(12.5mL/hr). If no reaction, may increase 50 mg/hr (12.5mL/hr) every 30 minutes, to a maximum rate of 400 mg/hour (100mL/hr).

☐ Subsequent doses – If patient tolerated initial infusion, start at 100 mg/hr (25mL/hr). If no reaction, may increase 100 mg/hr (25mL/hr) every 30 minutes, to a maximum rate of 400 mg/hour (100mL/hr).

Pause or stop the infusion for all infusion reactions. When reaction stops restart infusion at 50% of the previous rate. Discontinue and contact physician in the event

☐ Other: _____

Infusion Reaction Protocol:

√ Premier Health standard infusion reaction protocols

For Completion by Prior Authorization Team

IF THE PATIENT HAS INSURANCE OTHER THAN MEDICARE OR TRADITIONAL OHIO MEDICAID PRECERTIFICATION IS REQUIRED.

PLEASE OBTAIN PRECERTIFICATION AND INCLUDE AUTHORIZATION BELOW:

Precertification

Authorization #:_____ Date range: _____
# of infusions: _____

☐ No precertification necessary Name of person filling out this section: _____

If no precert required, list name of whom you spoke with at insurance company and on what date.

Name: _____Company: _____Date: _____

Provider signature_____

Printed provider name_____

Date_____ Time _____

Form revised: 11/2024