Agile Infusion Services LLC
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RITUXAN MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ *Patient's weight in pounds*_____

■ Diagnosis
Diagnosis and the most specific ICD-10 code available: _____

■ Details Needed for Approval

Rheumatoid Arthritis
- Has the patient had a failure, contraindication or allergy to Truxima or Ruxience? _____
- Has the patient been diagnosed with moderate-to-severe active RA? _____
- Is Rituximab being used with methotrexate? _____ If not, is there a contraindication/intolerance? _____
- Has the patient tried and failed at least a 3 month trial of methotrexate, leflunomide, sulfasalazine and/or hydroxychloroquine? _____ If not, is there an intolerance or contraindication to all conventional agents? _____
- Has the patient tried another biological immunomodulator agent FDA labeled or compendia supported for RA? _____
- Has the patient been treated with Rituximab in the past 16 weeks? _____
- Please provide us with detailed notes on disease status, progression, prognosis, past meds and a full history.

Pemphigus Vulgaris
- Has the patient had a failure, contraindication or allergy to Truxima or Ruxience? _____
- Has the patient been diagnosed with moderate-to-severe PV? _____
- Check off all clinical signs exhibited:
  ☐ Lesions/Erosions/Blisters ☐ Nikolsky sign ☐ Characteristic scarring and lesion distribution
- Include written report of Histopathologic confirmation by skin/mucous membrane biopsy.
- Include results demonstrating presence of autoantibodies as detected by direct or indirect immunofluorescence.
- Have you ruled out other causes of blistering or erosive skin and mucous membrane diseases? _____

■ Premedication Order
Oral medications to be taken by the patient at least 60 minutes prior to start of infusion treatment. May be taken at home:
☐ Acetaminophen _____mg ☐ Diphenhydramine _____mg ☐ Cetirizine 10mg

IV medications to be administered prior to start of the infusion treatment:
☐ Dexamethasone _____mg ☐ Famotidine _____mg
☐ Diphenhydramine _____mg ☐ Methylprednisolone _____mg

■ Rituxan (rituximab) Intravenous Order

Dose: _____ mg/kg

Rate:
☐ _____ ml over _____ minutes
☐ Start at _____ ml/hr, after _____ minutes increase to _____ ml/hr, after _____ minutes increase to _____ ml/hr

Volume:
☐ _____ ml of normal saline ☐ _____ ml of half normal saline ☐ _____ ml of D5W

Frequency: To be administered every _____ _____ for _____ _____. (Ex: every 2 days for 3 weeks)

After the infusion is complete, flush with normal saline. Check vitals and monitor for signs and symptoms of an infusion reaction at start, throughout infusion, and after completion.

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■ **Rescue Management in case of Infusion Therapy Reaction**

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Diphenhydramine 50mg IV and Methylprednisolone 125mg IV for allergic reactions.
- Albuterol sulfate 2.5ml by nebulizer for wheezing and respiratory reactions. Provide oxygen as needed.
- Famotidine 20mg IVP for minor cutaneous reactions which do not respond to diphenhydramine.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ **Documentation to Include**

- Patient demographics and insurance, including allergies and including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical.
- All relevant scans, tests and laboratory results (including CBC with platelet, quantitative immunoglobulins, Hepatitis B antigen, Hepatitis B core total antibody and QuantiFERON gold).
- If this is a new medication for the patient, chart notes which include decision to begin treatment. If the patient is already being treated on this therapy, provide last treatment date and notes.

■ **Ordering Provider Authorization**

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.