


RITUXIMAB REFERRAL FORM

PATIENT DEMOGRAPHICS:				
PATIENT NAME:		PATIENT'S CONTACT #:		
DATE OF REFERRAL:		ADDRESS:		
DATE OF BIRTH:		CITY, STATE, ZIP:		
FOR COPAY ASSISTANCE, PLEASE PROVIDE LAST 4 OF SSN:				
HEIGHT: _____ FEET _____ INCHES		GENDER: FEMALE MALE		
WEIGHT: _____ LB or _____ KG		ALLERGIES: SEE LIST NKDA		
PRIMARY DIAGNOSIS:		REQUIRED DOCUMENTATION:		
M05.10 - Rheumatoid arthritis, unspecified M05.79 - Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement M05.9 - Rheumatoid arthritis with rheumatoid factor, unspecified M06.9 - Rheumatoid lung disease with rheumatoid arthritis of unspecified site M31.3 - Wegener's granulomatosis M31.30 - Wegener's granulomatosis without renal involvement M31.31 - Wegener's granulomatosis with renal involvement M31.7 - Microscopic polyangiitis L10.0 - Pemphigus vulgaris Other - _____		1. INSURANCE CARD (Front & Back) 2. PATIENT DEMOGRAPHICS 3. MOST RECENT LABS 4. MEDICATION LIST 5. H & P 6. TRIED/FAILED THERAPIES 7. HEP B LAB RESULTS (HBSAG AND ANTI-HBC) 8. CBC WITH PLATELETS LAB RESULTS <input checked="" type="checkbox"/> Is the patient currently taking Methotrexate? Y N (Provide documentation)		
PRIMARY MEDICATION ORDER:		PRN & PREMEDICATIONS:		
<u>Rheumatoid Arthritis</u> <i>Initial and Maintenance</i> Rituximab 1000 mg IV on day 1 and day 15 (one course), continue subsequent courses every 6 months.		MEDICATIONS	30 minutes prior to every infusion	PRN
<u>GPA & MPA in Adults</u> <i>Initial</i> Rituximab 375 mg/m ² IV once weekly for 4 weeks. <i>Maintenance</i> Rituximab 500 mg IV on day 1 and day 15, then every 6 months thereafter.		Acetaminophen 650 mg PO		PRN every ____ hour for mild or moderate infusion reaction.
<u>PV in Adults</u> <i>Initial</i> Rituximab 1000 mg IV on day 1 and day 15. <i>Maintenance</i> Rituximab 500 mg IV at 12 months from initial dose, and every 6 months thereafter.		Diphenhydramine 25 mg PO		PRN every ____ hour for mild or moderate infusion reaction.
Other: Rituximab _____ <input checked="" type="checkbox"/> Labs Orders: CBC with Differential every 6 months BMP every 6 months FIRST DOSE: Y N <input checked="" type="checkbox"/> Biosimilar may be used according to payer guidelines, unless otherwise noted. <input checked="" type="checkbox"/> Refill x12 months unless otherwise noted.		Diphenhydramine 25 mg IV		PRN every ____ hour for mild or moderate infusion reaction.
		Methylprednisolone 125 mg IV	<input checked="" type="checkbox"/>	PRN every ____ hour for mild or moderate infusion reaction.
		Other: _____		PRN every ____ hour for mild or moderate infusion reaction.
LINE USE/CARE ORDERS:		ADVERSE REACTION & ANAPHYLAXIS ORDERS:		
<input checked="" type="checkbox"/> Start PIV/Access CVC <input checked="" type="checkbox"/> Flush device per FlexCare Infusion Policy & Procedure (See Reverse Side) Other Flush Orders: (Please fax other reaction orders if checking this box)		<input checked="" type="checkbox"/> Administer Acute Infusion and Anaphylaxis Medications per FlexCare Infusion Policy and Procedure (See Reverse Side) Other: (Please fax other reaction orders if checking this box)		
PRESCRIBER INFORMATION: Please check preferred form of communication.				
PROVIDER NAME:		PHONE:		
OFFICE CONTACT:		FAX:		
ADDRESS:		EMAIL:		
CITY, STATE, ZIP:		NPI:		
 PROVIDER SIGNATURE:		DATE:		

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FLEXCARE INFUSION CENTER'S ACUTE & ANAPHYLAXIS MEDICATION PROTOCOL:

**This table does not reflect non-medicinal interventions that are part of FlexCare's protocol, such as slowing or stopping the infusion and physician/911 notification.*

	MILD INFUSION REACTION	MODERATE INFUSION REACTION	SEVERE INFUSION REACTION/ANAPHYLAXIS
SYMPTOM CLASSIFICATION	<ul style="list-style-type: none"> Flushing Dizziness Headache Apprehension Diaphoresis Palpitations Nausea / Vomiting Pruitis 	<ul style="list-style-type: none"> Chest Tightness Shortness of Breath Hypo/hypertension (>20 mmHg Change in Systolic BP from Baseline) Increased Temperature (>2 Degrees Fahrenheit) Urticaria 	<ul style="list-style-type: none"> Hypo/hypertension (>40 mmHg Change in Systolic BP from Baseline). Increase Temperature (>2 Degrees Fahrenheit) with Rigors Shortness of Breath with Wheezing Laryngeal Edema Chest Pain Hypoxemia
TREATMENT PROTOCOL FOR ADULTS >66LBS	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500 mL at 125mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 50 mg IV or IM Inject epinephrine 0.3mg/0.3 mL IM into the midanterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl 1000mL bolus for an incomplete response to IM epinephrine. May repeat x1.
TREATMENT PROTOCOL FOR CHILDREN 33LBS - 66 LBS	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500mL at 75mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 1-2 mg/kg IM or slow IVP not to exceed 25mg/min <input checked="" type="checkbox"/> Inject epinephrine 0.15mg/0.15 mL IM into the mid-anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl bolus 20mL/kg for an incomplete response to IM epinephrine. May repeat x1.

FOR CHILDREN < 33 LBS FLEXCARE INFUSION UTILIZES THE REACTION ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

FLUSHING PROTOCOLS

		FLUSHING PROTOCOL Normal Saline*		LOCKING PROTOCOL Heparin Sodium	
		0.9% Sodium Chloride		10 Units/mL	100 Units/mL
PATIENT CLASSIFICATION	LINE TYPE	PRE-ADMIN	POST ADMIN	POST LAB DRAW	POST NS FLUSH*
ADULT > 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	10 mL	10 mL	5 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	10 mL	10 mL	5 mL
	Tunneled & non-Tunneled Catheters	5 mL	10 mL	10 mL	5 mL
PEDIATRIC 33 LBS - 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	5 mL	10 mL	3 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	5 mL	10 mL	3 mL
	Tunneled & non-Tunneled Catheters	5 mL	5 mL	10 mL	3 mL

FOR CHILDREN <33 LBS, FLEXCARE INFUSION UTILIZES THE FLUSHING ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

*0.9% NS will be substituted with Dextrose 5% or alternative only when indicated due to medication incompatibility with NS.