

RITUXIMAB

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

| PATIENT INFORMATION (Complete or Fax Existing Chart) | | PRESCRIBER INFORMATION | | | |
|--|--|---|------------------------|--|--|
| Name: DOB: | | Prescriber Name: | Prescriber Name: | | |
| Address: | | State License: | | | |
| City, State, Zip: | | I NIDLU: DEA: | NPI #: DEA: | | |
| Phone: Alt. Phone: | | Address: | Address: | | |
| Email: SS#: | | | City, State, Zip: | | |
| Gender: M F Weight:(lbs) Ht: | | Phone: Fax: | | | |
| Allergies: | | Office Contact: Phone: | Office Contact: Phone: | | |
| INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back) | | | | | |
| Primary Insurance: | | Secondary Insurance (If Applicable): | | | |
| Plan #: | | | | | |
| Group #: | | | Plan #: | | |
| RX Card (PBM): | | | | | |
| BIN: PCN: | | | | | |
| CLINICAL INFORMATION | | | | | |
| Primary ICD-10 Code: | Diagnosis Description: | | | | |
| | Diagnosis Description: | | | | |
| Hepatitis B Vaccination: Yes No | Patient on Methotrexate: ☐ Yes ☐ No Line Access: ☐ PIV ☐ Port ☐ PICC ☐ Midline | | | | |
| RITUXIMAB ORDERS | | | | | |
| Prescription type: New start Restart Continued therapy Total Doses Received: Date of Last Dose: Date of Last Dose: | | | | | |
| Medication | Dose/Frequency Refills | | | | |
| □ Bituvan® (Bituvimah) 100mg/10ml Vial | | | IVEIIII3 | | |
| ☐ Rituvan® (Rituvimah) 100mg/10ml Vial | ☐ 1000mg IV x 2 Dose | es separated by 14 days, repeat every 24 weeks | Kelliis | | |
| ☐ Rituxan® (Rituximab) 100mg/10ml Vial | _ | | Keillis | | |
| ☐ Rituxan® (Rituximab) 100mg/10ml Vial☐ Rituxan® (Rituximab) 500mg/50ml Vial☐ | ☐ Other: | es separated by 14 days, repeat every 24 weeks | Neillis | | |
| | ☐ Other: | es separated by 14 days, repeat every 24 weeks | Kems | | |
| | ☐ Other: | es separated by 14 days, repeat every 24 weeks | | | |
| ☐ Rituxan® (Rituximab) 500mg/50ml Vial | ☐ Other: | es separated by 14 days, repeat every 24 weeks eekly for 4 weeks | Keillis | | |
| ☐ Rituxan® (Rituximab) 500mg/50ml Vial ☐ Riabni™ (rituximab-arrx) 100mg Vial | ☐ Other: | eekly for 4 weeks separated by 2 weeks, followed by a 500mg IV infusion every 6 months | Keillis | | |
| ☐ Rituxan® (Rituximab) 500mg/50ml Vial ☐ Riabni™ (rituximab-arrx) 100mg Vial ☐ Riabni™ (rituximab-arrx) 500mg Vial | ☐ Other: | eekly for 4 weeks separated by 2 weeks, followed by a 500mg IV infusion every 6 months | | | |
| □ Rituxan® (Rituximab) 500mg/50ml Vial □ Riabni™ (rituximab-arrx) 100mg Vial □ Riabni™ (rituximab-arrx) 500mg Vial □ Ruxience® (Rituximab-pvvr) 100mg Vial | ☐ Other: | eekly for 4 weeks separated by 2 weeks, followed by a 500mg IV infusion every 6 months | Neillis | | |
| ☐ Rituxan® (Rituximab) 500mg/50ml Vial ☐ Riabni™ (rituximab-arrx) 100mg Vial ☐ Riabni™ (rituximab-arrx) 500mg Vial | ☐ Other: | eekly for 4 weeks separated by 2 weeks, followed by a 500mg IV infusion every 6 months | | | |
| □ Rituxan® (Rituximab) 500mg/50ml Vial □ Riabni™ (rituximab-arrx) 100mg Vial □ Riabni™ (rituximab-arrx) 500mg Vial □ Ruxience® (Rituximab-pvvr) 100mg Vial | ☐ Other: | eekly for 4 weeks separated by 2 weeks, followed by a 500mg IV infusion every 6 months | | | |
| □ Rituxan® (Rituximab) 500mg/50ml Vial □ Riabni™ (rituximab-arrx) 100mg Vial □ Riabni™ (rituximab-arrx) 500mg Vial □ Ruxience® (Rituximab-pvvr) 100mg Vial □ Ruxience® (Rituximab-pvvr) 500mg Vial | ☐ Other: | eekly for 4 weeks separated by 2 weeks, followed by a 500mg IV infusion every 6 months es separated by 14 days, repeat every 24 weeks | - Neillis | | |
| ☐ Rituxan® (Rituximab) 500mg/50ml Vial ☐ Riabni™ (rituximab-arrx) 100mg Vial ☐ Riabni™ (rituximab-arrx) 500mg Vial ☐ Ruxience® (Rituximab-pvvr) 100mg Vial ☐ Ruxience® (Rituximab-pvvr) 500mg Vial ☐ Pre-Medication ☐ Acetaminophen | ☐ Other: | eekly for 4 weeks separated by 2 weeks, followed by a 500mg IV infusion every 6 months es separated by 14 days, repeat every 24 weeks Directions | | | |
| ☐ Rituxan® (Rituximab) 500mg/50ml Vial ☐ Riabni™ (rituximab-arrx) 100mg Vial ☐ Riabni™ (rituximab-arrx) 500mg Vial ☐ Ruxience® (Rituximab-pvvr) 100mg Vial ☐ Ruxience® (Rituximab-pvvr) 500mg Vial ☐ Pre-Medication | ☐ Other: Frequency: ☐ 375mg/m2 once w ☐ 500mg IV infusion: ☐ Other: ☐ 1000mg IV x 2 Dos ☐ Other: ☐ Frequency: ☐ Toose/Strength ☐ 500mg | eekly for 4 weeks separated by 2 weeks, followed by a 500mg IV infusion every 6 months es separated by 14 days, repeat every 24 weeks Directions Take 1-2 tablets PO prior to infusion or post-infusion as directed | - Neillis | | |
| Rituxan® (Rituximab) 500mg/50ml Vial Riabni™ (rituximab-arrx) 100mg Vial Riabni™ (rituximab-arrx) 500mg Vial Ruxience® (Rituximab-pvvr) 100mg Vial Ruxience® (Rituximab-pvvr) 500mg Vial Pre-Medication Acetaminophen | ☐ Other: | eekly for 4 weeks separated by 2 weeks, followed by a 500mg IV infusion every 6 months es separated by 14 days, repeat every 24 weeks Directions Take 1-2 tablets PO prior to infusion or post-infusion as directed Take 1 tablet PO prior to infusion or as directed OR | | | |
| ☐ Rituxan® (Rituximab) 500mg/50ml Vial ☐ Riabni™ (rituximab-arrx) 100mg Vial ☐ Riabni™ (rituximab-arrx) 500mg Vial ☐ Ruxience® (Rituximab-pvvr) 100mg Vial ☐ Ruxience® (Rituximab-pvvr) 500mg Vial ☐ Pre-Medication ☐ Acetaminophen | ☐ Other: Frequency: ☐ 375mg/m2 once w ☐ 500mg IV infusion : ☐ Other: ☐ 1000mg IV x 2 Dos ☐ Other: ☐ requency: ☐ Dose/Strength ☐ 500mg ☐ 25mg IV/PO ☐ 50mg IV/PO | eekly for 4 weeks separated by 2 weeks, followed by a 500mg IV infusion every 6 months es separated by 14 days, repeat every 24 weeks Directions Take 1-2 tablets PO prior to infusion or post-infusion as directed Take 1 tablet PO prior to infusion or as directed OR Inject contents of 1 vial IV prior to infusion or as directed | | | |
| Rituxan® (Rituximab) 500mg/50ml Vial Riabni™ (rituximab-arrx) 100mg Vial Riabni™ (rituximab-arrx) 500mg Vial Ruxience® (Rituximab-pvvr) 100mg Vial Ruxience® (Rituximab-pvvr) 500mg Vial Pre-Medication Acetaminophen | ☐ Other: | eekly for 4 weeks separated by 2 weeks, followed by a 500mg IV infusion every 6 months es separated by 14 days, repeat every 24 weeks Directions Take 1-2 tablets PO prior to infusion or post-infusion as directed Take 1 tablet PO prior to infusion or as directed OR Inject contents of 1 vial IV prior to infusion or as directed | | | |
| Rituxan® (Rituximab) 500mg/50ml Vial Riabni™ (rituximab-arrx) 100mg Vial Riabni™ (rituximab-arrx) 500mg Vial Ruxience® (Rituximab-pvvr) 100mg Vial Ruxience® (Rituximab-pvvr) 500mg Vial Pre-Medication Acetaminophen Diphenhydramine | ☐ Other: | eekly for 4 weeks separated by 2 weeks, followed by a 500mg IV infusion every 6 months es separated by 14 days, repeat every 24 weeks Directions Take 1-2 tablets PO prior to infusion or post-infusion as directed Take 1 tablet PO prior to infusion or as directed OR Inject contents of 1 vial IV prior to infusion or as directed | - Neillis | | |

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.



RITUXIMAB

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

Date: ___

| | riedse seriu a copy of The Patient's Hisurance Carus (Front & Back) | | | | |
|---|---|---|---|--|--|
| Mild reaction protocol: | | | | | |
| oximes Diphenhydramine 25mg IV, one time, for pruritu | JS. | | | | |
| If symptoms worsen, see orders for moderate to se | vere reactions. | | | | |
| Moderate reaction protocol: | | | | | |
| oximes Acetaminophen 650mg PO, one time, for pyrexi | a or rigors | | | | |
| oximes Diphenhydramine 50mg IV, one time, for pruritu | us or urticaria | | | | |
| ☑ Methylprednisolone 125mg IV, one time, for res | spiratory or neurologic syr | nptoms | | | |
| If symptoms worsen, see interventions for severe re | eactions | | | | |
| Severe reaction protocol: (Call 911 if initiated): | | | | | |
| ☑ Titrate oxygen via continuous flow per nasal car | nnula or face mask to mair | ntain spO2 of greater tha | n ninety-five percent (>95%) | | |
| ☑ Diphenhydramine 50mg IV,one time, for respira | tory symptoms, edema, o | r anaphylaxis | | | |
| ⊠ Sodium Chloride 0.9% 500mL IV over 30-60 min | , one time, for cardiovascu | ular symptoms | | | |
| ☑ Epinephrine 0.3mg/0.3mL IM into mis-anterolat | eral aspect of thigh of ana | aphylaxis, may repeat x1 | in 5-15 minutes if symptoms are not resolved or | | |
| worsen | | | | | |
| FLUSHING & LOCKING ORDERS | | | | | |
| Flushing Protocol (>66lbs/33kg) | | | | | |
| PIV and Midline: | | Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter: | | | |
| ☑ 0.9% Sodium Chloride 2-5mL IV flush before and | d after each infusion | ☑ 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL | | | |
| | | IV flush after infusion/lab draw | | | |
| Locking Protocol (>66lbs/33kg) | | I | | | |
| PIV and Midline: | PICC: ⊠ Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush | | Implanted Port, Tunneled Catheter, and Non- tunneled Catheter: | | |
| ☐ Heparin Sodium 10 units/mL 1mL IV final | | | | | |
| flush post normal saline flush | | | ⋈ Heparin Sodium 100 units/mL 3-5mL IV final | | |
| | | | flush post normal saline flush | | |
| ** May substitute Dextrose 5% in Water, or alternative, | for 0.9& Sodium Chloride, w | hen indicated due to incon | npatibility with medications bring infused | | |
| SIGNATURE | | | | | |
| We hereby authorize Talis Healthcare LLC to provide | | | | | |

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

Prescriber Signature

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.