Provider Order Form

RITUXAN (RITUXIMAB BIOSIMILARS)

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Non-Hodgkin's Lymphoma (NHL) C85. _____ ☐ Rheumatoid Arthritis M05. _____ ☐ Ganulomatosis with Polyangiitis M31. ___

☐ Chronic Lymphocytic Leukemia (CLL) C91. ___ ☐ Pemphigus Vulgaris L10.0 ☐ Microscopic Polyangiitis M31.7

☐ Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg

☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg

☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg

☐ Cetrizine (Zyrtec) 10 mg PO

☐ Other: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☐ Rituxan (Rituximab), IV	☐ 500 mg	☐ Day 0 and 14, repeat every 24 weeks
☐ Rituximab Biosimilar, IV:	☐ 1000 mg	☐ Every 24 weeks.
☐ Truxima ☐ Ruxience ☐ Riabni	☐ 375 mg/m²	☐ Weekly x 4 weeks

Other: _____

Refills ☐ Zero ☐ 12 months ☐ _____ Order valid for 1 year unless otherwise stated. _____

☒ Flush with 0.9% sodium chloride at infusion completion.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC	☐ at each dose	☐ every _____
☐ CMP	☐ at each dose	☐ every _____
☐ CRP	☐ at each dose	☐ every _____
☐ Other _____	☐ at each dose	☐ every _____

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ Hepatitis B status results

Provider Signature _____ Date _____