PREMIER INFUSION CENTER

📜 Ruxience (rituximab-pvvr) IV Infusion Order Form

📞 405-442-7577 📠 405-442-7223
📧 orders@premierinfusioncenter.com

👤 Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / _____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **Weight:** _____ kg **Height:** _____ cm/in
- **Allergies:** ☐ NKDA ☐ _____
- **Treatment Status:** ☐ New ☐ Continue **Last Treatment Date:** ____ / ____ / ____

🔹 Diagnosis (ICD-10 Selection)

☐ C85.80 – Non-Hodgkin lymphoma, unspecified
☐ M06.9 – Rheumatoid arthritis, unspecified
☐ D59.10 – Autoimmune hemolytic anemia
☐ M31.30 – Granulomatosis with polyangiitis
☐ M31.7 – Microscopic polyangiitis
☐ Other: _____ **ICD-10 Code:** _____

🔹 Infusion Order

- **Induction Options:**
  ☐ 375 mg/m² IV weekly × 4 doses
  ☐ 1000 mg IV on Day 1 and Day 15
- **Maintenance Options:**
  ☐ 1000 mg IV every 6 months
  ☐ Other: _____ mg/m² IV every _____ weeks
- ☐ Dilute in 250–500 mL 0.9% sodium chloride
- ☐ Infuse per manufacturer protocol:
  First infusion: Start at 50 mg/hr, increase by 50 mg/hr every 30 min to max 400 mg/hr
  Subsequent infusions: Start at 100 mg/hr, increase by 100 mg/hr every 30 min to max 400 mg/hr

- ☐ Observation: ☐ 60 minutes post-infusion
- ☐ Refills: ☐ None ☐ 6 months ☐ 12 months ☐ Other: _____

🔹 Line Use & Access

☐ Start PIV ☐ Access CVC ☐ Use PICC Line ☐ Flush per standard infusion protocol

🔹 Adverse Reaction & Anaphylaxis Orders

☐ Premier Infusion Center Protocol (premierinfusioncenter.com)
☐ Other – please fax preferred reaction orders to 405-442-7223

🔹 Premedication (Required)

☐ Acetaminophen: ☐ 650 mg ☐ 1000 mg ☐ PO
☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ Methylprednisolone: ☐ 100 mg ☐ 125 mg ☐ IV
☐ Cetirizine: ☐ 10 mg ☐ PO
☐ Other: _____ **Dose:** _____ **Route:** _____

🔹 Laboratory Monitoring

☐ CBC ☐ CMP ☐ CRP ☐ ESR
☐ Hepatitis B Panel (HBsAg and anti-HBc required prior to first dose)
☐ TB Screening
☐ Other: _____
Frequency: ☐ Prior to first dose ☐ Each infusion ☐ Monthly ☐ Other: _____
☐ Physician office will order labs only

🔹 Clinical Documentation Checklist

☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list
☐ Documentation of prior therapies or intolerance
☐ Hepatitis B screening results

- **Ordering Provider & Demographics**

  - **Name: _____**
  - **NPI: _____ License #: _____**
  - **Contact: _____ Phone: _____ Fax: _____**
  - **Email: _____**
  - **Signature: _____ Date: ____ / _____ / _____**