Beacon Infusion
Healthcare Services

Headquarters Location:
1075 Stephenson Ave, Suite D-2, Oceanport, NJ 07757
Telephone: (833) 223-2266 Fax: (732) 329-2322

RITUXIMAB MEDICATION ORDER

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

■ Diagnosis

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

■ Details Needed for Authorization *Other indications may require other documentation.*

Rheumatoid Arthritis

- If order is for Rituxan, does the patient have a failure, contraindication or allergy to Truxima or Ruxience? _____
- Has the patient been diagnosed with moderate-to-severe active RA? _____
- Is Rituximab being used in combination 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? _____
- Mas the patient been treated with Rituximab in the past 16 weeks? _____
- Please provide us with detailed notes on disease status, progression, activity, prognosis, past medications trialed, and full history.

Pemphigus Vulgaris

- If order is for Rituxan, does the patient have a failure, contraindication or allergy to Truxima or Ruxience? _____
- _____
- Has the patient been diagnosed with moderate-to-severe PV? _____
- Indicate 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 before coming in.:

☐ Acetaminophen _____mg ☐ Cetirizine _____mg ☐ Diphenhydramine _____mg

IV medications to be administered prior to start of the infusion treatment:

☐ Dexamethasone _____mg ☐ Famotidine _____mg ☐ Methylprednisolone _____mg
☐ Diphenhydramine _____mg ☐ Metoclopramide _____mg ☐ _____

■ Rituximab Order

☐ Rituxan ☐ Ruxience ☐ Truxima

☐ DAW: Please check here to administer only as written. If not checked, we may substitute your brand of choice depending on availability / allocation. (If your brand choice is unavailable and this box is checked, a new order will be needed to change brands.)

Continued …..

RITUXIMAB MEDICATION ORDER, CONTINUED …

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

Dose: _____ mg/kg **Patient's height in ft/in: _____** **Patient's weight in lbs: _____**

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)*

☐ If filtered tubing is required, indicate particle size filter to be used: 0.2µ or 1.2µ
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.

■ Rescue Management in case of Infusion Therapy Reaction

Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction. Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed. 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 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's Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ NPI #: _____ License: _____

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

Fax this order and all supporting documentation to (732) 329-2322.