Trinity Health Muskegon & Shelby Infusion Clinics
Muskegon: 1500 Sherman BLVD, Muskegon, MI 49444
Shelby: 72 S. State St. Shelby, MI 49455
Fax: 231-727-4328

Rituximab (Rituxan®) or Biosimilar

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. Trinity Health Muskegon will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____ **Site of Service:** ☒ TH Muskegon

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

Patient Name: _____ **Date of Birth**: ____/____/____ **Weight:** _____kg **Height:** _____cm **Allergies:** _____	**Primary Insurance:** _____ **Member ID:** _____ **Secondary Insurance:** _____ **Member ID:** _____
Diagnosis Diagnosis Code (ICD-10): _____ Indication: _____ Target start date: _____	**Lab Orders** ☐ CBC w/ diff (specify frequency): _____ ☐ Other: _____

Note to Provider: Viral hepatitis B screening required prior to therapy initiation. Additional screening for hepatitis C, HIV, and TB may be warranted.

Hold and Notify Provider: ANC below 1.5, Plt below 75K; signs/symptoms of active infection.

Pre-Medications

☐ Acetaminophen 650mg PO, 30-60 minutes prior to infusion
☐ Diphenhydramine 25mg IVP, 30-60 minutes prior to infusion
☐ Methylprednisolone 100mg IVP, 30-60 minutes prior to infusion
☐ Loratadine 10mg PO, 30-60 minutes prior to infusion
☐ Hydrocortisone 50 mg IVP, 30-60 minutes prior to infusion
☐ Other: _____

℞ Rituximab (Or Biosimilar)

☐ **Pharmacy to Select** ☐ DAW: _____

Dose:

☐ 1000 mg ☐ 375 mg/m^2 ☐ Other: _____

Frequency:

☐ Day 1 and 15, ☐ Repeating every 6 months
☐ Weekly for ___ weeks
☐ Once
☐ Other: _____

Nursing Orders:

Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary:
sodium chloride 0.9 % bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN

Provider Name: _____	Provider Signature: _____
Office Phone Number: _____	Office Fax Number: _____
Attending Physician Name: _____ *(If ordering provider is an advanced practice practitioner)* *Note: This order is valid for 12 months from date of physician signature.*	

Reviewed: Nov 2023