Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____

Current Height: _____ Current Weight_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Related Diagnosis Code (ICD-10 code): _____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

CMC CONWAY MEDICAL CENTER

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Rituximab Treatment Plan

Patient Name: _____ Patient DOB _____

General

☐ Diagnosis- _____ ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last infusion ____/____/_____

Authorized Treatment Duration ☐ 12 Months ☐ Other _____

***Note: Pharmacy will interchange biosimilar product per insurance approval unless box on page 4 is selected prohibiting interchange. If interchange is **NOT** allowed by provider, please indicate preferred product here:

Preferred Product: _____

☑ Pharmacy may round dose for BSA based regimens to nearest 50mg as long as dose adjustment does not exceed 10% of prescribed dose

☑ Initial infusion to be initiated at 50mg / hr and increased in 50mg / hr increments every 30 min to a maximum rate of 400mg / hr. Following initial infusion where tolerance was demonstrated, subsequent infusions may be initiated at 100mg / hr and increased in 100mg / hr increments to a maximum rate of 400mg / hr. If patient experiences any s/sx of intolerance, hypersensitivity, or anaphylaxis, stop infusion and notify provider.

Infusion (Month 1 to 12) Duration: 12 Months

☑ Vital Signs (Month 1 to 12)

every 30 min, Resp, BP, HR, Temperature on admission to the unit and prior to infusion HR, BP every 30 minutes during the infusion and prior to discharge

Pre- Treatment Medications

Tylenol (Month 1 to 12)

☑ *650 mg, Oral, Tab, Day of Tx*

Comments: Administer 30 minutes before rituximab dose

Benadryl (Month 1 to 12)

☑ *50 mg, IV Push, Injection, Day of Tx*

Comments: Administer 30 minutes before rituximab dose

SOLU-Medrol (Month 1 to 12) **(Recommended)**

☐ *40 mg, IV Push, Powder-Inj, Day of Tx*

Comments: Administer 30 minutes before rituximab dose

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Rituximab Treatment Plan

☐ *125 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before rituximab dose

Rituximab Dose

☐ *1,000 mg, IV Piggyback*
Comments: -Prepare as a standard 2mg per ml solution- Infuse initial dose of rituximab at 25 ml/hr x 30 minutes. -If tolerated without symptoms, increase infusion rate by 25ml/hr every 30 minutes to a maximum of 200ml/hr (ie 400 mg / hr)

☐ 250mg / m^2 = _____ mg
Comments: -Prepare as a standard 2mg per ml solution- Infuse initial dose of rituximab at 25 ml/hr x 30 minutes. -If tolerated without symptoms, increase infusion rate by 25ml/hr every 30 minutes to a maximum of 200ml/hr (ie 400 mg / hr)

☐ 375mg / m^2 = _____ mg
Comments: -Prepare as a standard 2mg per ml solution- Infuse initial dose of rituximab at 25 ml/hr x 30 minutes. -If tolerated without symptoms, increase infusion rate by 25ml/hr every 30 minutes to a maximum of 200ml/hr (ie 400 mg / hr)

Rituximab Frequency (New Start)

☐ Infuse at day 0 and day 14 followed by every 12 weeks (3 months)
☐ Infuse at day 0 and day 14 followed by every 16 weeks (4 months)
☐ Infuse at day 0 and day 14 followed by every 20 weeks (5 months)
☐ Infuse at day 0 and day 14 followed by every 24 weeks (6 months)
☐ Infuse every 7 days x 4 doses

Rituximab Frequency (Established Patient)- Note: No HBV or TB screening completed/evaluated by OIS

☐ Infuse every 12 weeks (3 months)
☐ Infuse every 16 weeks (4 months)
☐ Infuse every 20 weeks (5 months)
☐ Infuse every 24 weeks (6 months)

☑ Normal Saline Infused at 100 ml / hr as needed for rituximab infusion

☑ Communication Order (Month 1 to 12)
Patient must stay in infusion area for 30 min post infusion. If vital signs normal may be discharged to home. If abnormal, call physician.

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____

Rituximab Treatment Plan

☑ Communication Order (Month 1 to 12)
Ensure results of Hepatitis B surface antigen testing and record results if not present in medical record. Results must be within last 12 months.

☑ Communication Order (Month 1 to 12)
Ensure negative PPD or other test to exclude latent tuberculosis. Results must be within the last 12 months.

☑ Communication Order (Month 1 to 12)
Ensure negative HCG urine screening completed prior to each infusion for females 11-55 years of age with no history of hysterectomy or bilaterial oophorectomy

☑ Notify Provider (Month 1 to 12)
for fever/chills, chest pain, hypotension, hypertension, dyspnea, Pruritis, urticaria, persistent flushing Temperature > 100 or HR <50 or > 130

☑ Notify Provider (Month 1 to 12)
For POSITIVE results of PPD test or other test to exclude latent tuberculosis. Results must be within the last 12 months.

☑ Notify Provider (Month 1 to 12)
For POSITIVE results of Hepatitis B surface antigen or if results are not available. Results must be within the last 12 months.

☑ Notify Provider (Month 1 to 12)
for positive HCG urine screen prior to infusion initiation.

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

Labs (Month 1 to 12) Duration: 12 Months

☑ Quantiferon(R)-TB Gold, 4T, Incu-(36971) (If Needed)
☑ Hepatitis B Surface Antibody, Qual-(499) (If Needed)
☑ Hepatitis B Surface Antigen w Ref/Conf-(498) (If Needed)
☑ Hepatitis B Core Antibody, Total-(501) (If Needed)
☑ HCG Pregnancy Screening- Urine (If Needed)

Patient Monitoring Acknowledgement:

***** CMC Outpatient Infusion Services (OIS) shall insure Hepatitis B and Tuberculosis screening has been completed within 12 months prior to initiation of new start infusions and human chorionic gonadotropin (HCG) urine screening is completed prior to each infusion for female patients 11-55 years of age with no history of hysterectomy or bilaterial oophorectomy. If initial Hepatitis B, TB, or ongoing HCG screening is positive, OIS staff shall ensure referring provider is aware and has cleared patient to proceed with therapy

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____

Rituximab Treatment Plan

prior to infusion initiation.

Provider Initials_____

** Referring provider acknowledges that ongoing patient screening, monitoring, and management of items including but not limited to Hepatitis, PCP Prophylaxis, HIV/AIDS, Varicella Zoster, Tuberculosis, etc. is the responsibility of the referring provider and it beyond the scope of service provided by the outpatient infusion therapy team.

Provider Initials_____

☐ Biosimilar Substitution **NOT** permitted

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____