FLOURISH™
HEALTH GROUP

RITUXIMAB REFERRAL FORM

FAX: (219) 319-5121 | PHONE: 1-800-799-CARE (2273) | EMAIL: hello@flourishhealth.com |
VISIT: flourishhealth.com

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PATIENT'S CONTACT #:
DATE OF REFERRAL:	ADDRESS:
DATE OF BIRTH:	CITY, STATE, ZIP:
FOR COPAY ASSISTANCE, PLEASE PROVIDE LAST 4 OF SSN:	
HEIGHT: _____ FEET _____ INCHES	GENDER: FEMALE ☐ MALE ☐
WEIGHT: _____ LB or _____ KG	ALLERGIES: SEE LIST ☐ NKDA ☐

PRIMARY DIAGNOSIS:

- ☐ M05.10 - Rheumatoid arthritis, unspecified
- ☐ M05.79 - Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement
- ☐ M05.9 - Rheumatoid arthritis with rheumatoid factor, unspecified
- ☐ M06.9 - Rheumatoid lung disease with rheumatoid arthritis of unspecified site
- ☐ M31.3 - Wegener's granulomatosis
- ☐ M31.30 - Wegener's granulomatosis without renal involvement
- ☐ M31.31 - Wegener's granulomatosis with renal involvement
- ☐ M31.7 - Microscopic polyangiitis
- ☐ L10.0 - Pemphigus vulgaris
- ☐ Other -

REQUIRED DOCUMENTATION:

1. INSURANCE CARD (Front & Back)
2. PATIENT DEMOGRAPHICS
3. MOST RECENT LABS
4. MEDICATION LIST
5. H & P
6. TRIED/FAILED THERAPIES
7. HEP B LAB RESULTS (HBSAG AND ANTI-HBC)
8. CBC WITH PLATELETS LAB RESULTS

☑ Is the patient currently taking Methotrexate? ☐ Y ☐ N
(Provide documentation)

PRIMARY MEDICATION ORDER:

Rheumatoid Arthritis

Initial and Maintenance

☐ Rituximab 1000 mg IV on day 1 and day 15 (one course), continue subsequent courses every 6 months.

GPA & MPA in Adults

Initial

☐ Rituximab 375 mg/m2 IV once weekly for 4 weeks.

Maintenance

☐ Rituximab 500 mg IV on day 1 and day 15, then every 6 months thereafter.

PV in Adults

Initial

☐ Rituximab 1000 mg IV on day 1 and day 15.

Maintenance

☐ Rituximab 500 mg IV at 12 months from initial dose, and every 6 months thereafter.

☐ Other: Rituximab _____

☑ Labs Orders: ☐ CBC with Differential every 6 months ☐ BMP every 6 months

FIRST DOSE: ☐ Y ☐ N

☑ Biosimilar may be used according to payer guidelines, unless otherwise noted.

☑ Refill x12 months unless otherwise noted.

PRN & PREMEDICATIONS:

MEDICATIONS	30 minutes prior to every infusion	PRN
Acetaminophen 650 mg PO	☐	PRN every ___ hour for mild or moderate infusion reaction.
Diphenhydramine 25 mg PO	☐	PRN every ___ hour for mild or moderate infusion reaction.
Diphenhydramine 25 mg IV	☐	PRN every ___ hour for mild or moderate infusion reaction.
Methylprednisolone 125 mg IV	☑	PRN every ___ hour for mild or moderate infusion reaction.
Other: _____	☐	PRN every ___ hour for mild or moderate infusion reaction.

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per Flourish Health Group's Policy & Procedure (See Reverse Side)

☐ Other Flush Orders: (Please fax other reaction orders if checking this box)

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

☑ Administer Acute Infusion and Anaphylaxis Medications per Flourish Health Group's Policy and Procedure (See Reverse Side)

☐ Other: (Please fax other reaction orders if checking this box)

PRESCRIBER INFORMATION: Please check preferred form of communication.

PROVIDER NAME:	PHONE:
OFFICE CONTACT:	☐ FAX:
ADDRESS:	☐ EMAIL:
CITY, STATE, ZIP:	NPI:

PROVIDER SIGNATURE: _____ DATE:

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FLOURISH HEALTH'S ACUTE & ANAPHYLAXIS MEDICATION PROTOCOL:

**This table does not reflect non-medicinal interventions that are part of Flourish Health Group's protocol, such as slowing or stopping the infusion and physician/911 notification.*

	MILD INFUSION REACTION	MODERATE INFUSION REACTION	SEVERE INFUSION REACTION/ANAPHYLAXIS
SYMPTOM CLASSIFICATION	• Flushing • Dizziness • Headache • Apprehension • Diaphoresis • Palpitations • Nausea / Vomiting • Pruitis	• Chest Tightness • Shortness of Breath • Hypo/hypertension (>20 mmHg Change in Systolic BP from Baseline) • Increased Temperature (>2 Degrees Fahrenheit • Urticaria	• Hypo/hypertension (>40 mmHg Change in Systolic BP from Baseline). • Increase Temperature (>2 Degrees Farenheit) with Rigors • Shortness of Breath with Wheezing • Laryngeal Edema • Chest Pain • Hypoxemia
TREATMENT PROTOCOL FOR ADULTS >66LBS	☒ Administer PRN medications per Physician order	☒ Administer PRN medications per Physician order	☒ Apply oxygen via ambu bag or high flow nasal canula, if vomiting. ☒ Administer 0.9% NaCl 500 mL at 125mL/hr to maintain IV access. ☒ Administer diphenhydramine 50 mg IV or IM Inject epinephrine 0.3mg/0.3 mL IM into the midantero-lateral aspect of the thigh; repeat in 5-15 minutes if needed. ☒ Administer 0.9% NaCl 1000mL bolus for an in-complete response to IM epinephrine. May repeat x1.
TREATMENT PROTOCOL FOR CHILDREN 33LBS - 66 LBS	☒ Administer PRN medications per Physician order	☒ Administer PRN medications per Physician order	☒ Apply oxygen via ambu bag or high flow nasal canula, if vomiting. ☒ Administer 0.9% NaCl 500mL at 75mL/hr to main-tain IV access. ☒ Administer diphenhydramine 1-2 mg/kg IM or slow IVP not to exceed 25mg/min ☒ Inject epinephrine 0.15mg/0.15 mL IM into the mid-anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. ☒ Administer 0.9% naCl bolus 20mL/kg for an in-complete response to IM epinephrine. May repeat x1.

FOR CHILDREN < 33 LBS FLOURISH HEALTH UTILIZES THE REACTION ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

FLUSHING PROTOCOLS

		FLUSHING PROTOCOL Normal Saline*		LOCKING PROTOCOL Heparin Sodium		
		0.9% Sodium Chloride		*10 Units/mL*	*100 Units/mL*	
PATIENT CLASSIFICATION	LINE TYPE	PRE-ADMIN	POST ADMIN	POST LAB DRAW	POST NS FLUSH*	
ADULT > 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL	
	Midline	3 mL	3 mL		3 mL	
	Implanted Port	5 mL	10 mL	10 mL		5 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	10 mL	10 mL	5 mL	
	Tunneled & non-Tun-neled Catheters	5 mL	10 mL	10 mL	5 mL	
PEDIATRIC 33 LBS - 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL	
	Midline	3 mL	3 mL		3 mL	
	Implanted Port	5 mL	5 mL	10 mL	3 mL	
	Peripherally Inserted Central Catheters (PICC)	5 mL	5 mL	10 mL	3 mL	
	Tunneled & non-Tun-neled Catheters	5 mL	5 mL	10 mL	3 mL	

FOR CHILDREN <33 LBS, FLOURISH HEALTH UTILIZES THE FLUSHING ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

**0.9% NS will be substituted with Dextrose 5% or alternative only when indicated due to medication incompatibility with NS.*