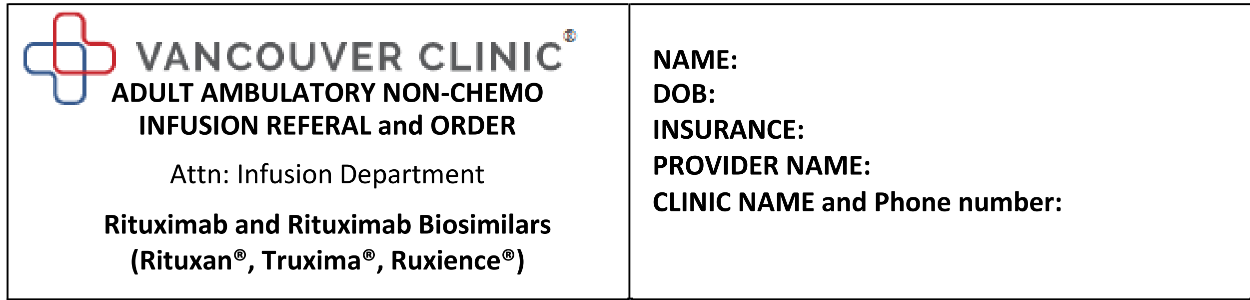


VANCOUVER CLINIC® **ADULT AMBULATORY NON-CHEMO INFUSION REFERAL and ORDER** Attn: Infusion Department **Rituximab and Rituximab Biosimilars (Rituxan®, Truxima®, Ruxience®)**	**NAME:** **DOB:** **INSURANCE:** **PROVIDER NAME:** **CLINIC NAME and Phone number:**

Weight:________lb/kg Height:______inch/cm
Diagnostic Code ICD-10:________________ Diagnosis:____

□ Initial Consult □ Annual Renewal
Treatment Start Date: _______________

****These orders will expire after 365 days; new orders are needed after the expiration date****

This form serves as a referral to infusion services and for medication ordering.
Patients will be seen by our internal infusion clinician for purposes of providing care.

GUIDELINES FOR ORDERING:

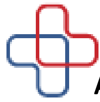
- Send FACE SHEET and H&P, relevant labs and/or most recent chart note
- Vancouver clinic infusion service will initiate Adverse Reaction Algorithm per our service protocol.
- Pre-medication(s) based on protocol (if needed)
- If pre-screening test and labs are not accessible through Epic, please fax a copy of request lab as well (see below). Otherwise, authorized Vancouver Clinic infusion clinician to order the lab.
- Patient must be able to ambulate independently (if patient needs assistance with restrooming, a personal caregiver or capable family member must accompany and remain with patient for the duration of the appointment).
- Reference drug or biosimilar product will be ordered and administered based on insurance formulary requirements.

PRE-SCREENING/LAB:

- CBC and differential within the last 30 days
- Hepatitis B surface antigen and core antibody total
- Tuberculin test (PPD or QuantiFERON Gold blood test). If result is indeterminate, a follow up chest X-ray must be performed to rule out TB.
- CMP

Please fax the completed form and pertinent information to Fax: 360-604-1776

***Vancouver Clinic Outpatient Infusion Service** - 700 NE 87th Ave Suite 330, Vancouver, WA 98664*
Phone: 360-541-3245


VANCOUVER CLINIC®

ADULT AMBULATORY NON-CHEMO INFUSION REFERAL and ORDER Attn: Infusion Department **Rituximab and Rituximab Biosimilars (Rituxan®, Truxima®, Ruxience®)**	**NAME:** **DOB:** **INSURANCE:** **PROVIDER NAME:** **CLINIC NAME and Phone number:**

MEDICATIONS:

- ☐ Rituximab (Rituxan®), rituximab-abbs (Truxima®), or rituximab-pvvr (Ruxience®) 1000 mg in sodium chloride 0.9% 250 mL, intravenous, on day 1 and day 15 every 6 months. Infusion titrated up based on protocol.

- ☐ Rituximab (Rituxan®), rituximab-abbs (Truxima®), or rituximab-pvvr (Ruxience®) 500 mg in sodium chloride 0.9% 250 mL, intravenous, on day 1 and day 15 every 6 months. Infusion titrated up based on protocol.

- ☐ Rituximab (Rituxan®), rituximab-abbs (Truxima®), or rituximab-pvvr (Ruxience®) 375 mg/m^2 = _______mg, in sodium chloride 0.9% 250 mL, intravenous, once weekly for _______dose(s). Infusion titrated up based on protocol.

Provider's signature: ____

Provider's printed name: _____________________________**Date:**__________________

Please fax the completed form and pertinent information to Fax: 360-604-1776

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