KabaFusion
Patient-Focused Infusion Therapy

Rituxan (Rituximab) Patient Referral and Prescription Sheet

Return Signed Rx via Fax to: 704.583.2130

Date:	To:	From:
Phone: **866.583.2140**	Fax:	Number of Pages:

Patient Information

Patient Name:	**DOB:**	**Height:**
Allergies:		**Weight:**

Medication Order

Rituximab:

❒ Rituximab: 375mg x _____ BSA (m^2) = _____IV every _____ for _____ courses.

❒ Rituximab: _____

Refills

-First Rituximab IV dose is to be administered in a controlled environment setting then subsequent doses in the home setting
-Dilute Rituxan to a final concentration of 1 mg/mL - 4 mg/mL with either 0.9% Sodium Chloride, or 5% Dextrose

Diagnosis	ICD-10	Diagnosis	ICD-10
❒ Rheumatoid Arthritis	M06. 9	❒ Wegener's Granulomatosis	M31.3
❒ Chronic Lymphocytic Leukemia (CLL)	C91.10	❒ Pemphigus Vulgaris (PV)	L10.0
❒ Non-Hodgkin's Lymphoma (NHL)	C85. 9	Other:	
❒ Neuromyelitis Optica [Devic]	G36.0		

IV Access Device: ❒ Peripheral ❒ Central

Lab order: ❒ CBC with diff ❒ CMP ☐ _____

Pre-medications:

❒ Diphenhydramine: _____ ❒ PO ❒ IV
❒ Acetaminophen: _____ ❒ PO ❒ IV
❒ Methylprednisolone: _____ ❒ IV
❒ Other pre-meds: _____
❒ **Hydration:** Infuse 500 mL of Normal Saline with Rituximab infusion
❒ **Anaphylaxis Protocol: Epinephrine Auto-Injector dual pack:**
Adult: 0.3 mg Children: 0.15 mg
Administer epinephrine IM in the event of anaphylaxis.
May repeat x 1 as needed, Call 911. **Refill x 1yr**

If applicable, flush IV access device per KabaFusion protocol:

Access	NS	Heparin
Peripheral	1-3 mL before/after use	10 U/mL 1-2 mL after last NS flush
Midline, Central (non-port), PICC	5-10 ml before/after use 5-20 ml after blood draw	10 U/mL 3-5 mL after last NS flush 5 mL after the blood draw
Implanted Port	5-10 mL before/after use. 20mL after blood draw	100 U/mL 5 mL after last NS flush 5 mL after the blood draw
Tunneled	5-10 mL before/after use 20mL after blood draw	10 U/mL 3-5 mL after last NS flush 5 mL after the blood draw
Groshong PICC, Midline	5-10 mL before/after use 10 mL after blood draw	None

I authorize KabaFusion and its representatives to act as an agent and initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to KabaFusion.

Prescriber Signature: _____ Date: _____

Print Prescriber Name: _____ NPI#: _____

DOCUMENTATION – PLEASE FAX TO KABAFUSION

☐ **Rx Order** – include dose, route of administration, frequency, duration, & pre-medications OR use the Rx order form above
☐ **Patient Demographics** – include **insurance** information. We will obtain authorization unless the insurance dictates otherwise.
☐ **H & P OR progress note(s)** describing diagnosis, clinical status, and clinical symptoms.
☐ **TB and Hepatitis B Virus (HBV) screening results** (required prior to Rituximab initiation) – **HBsAg and anti-HBc.**
☐ Most recent lab results for: **BUN/Creatinine** (preferred within last 90 days), **CMP Panel and CBC with Differential**