Edward-Elmhurst Cancer Centers
120 Spalding Drive; Suite 111; Naperville, IL 60540 Phone: 630/646-2273 Fax: 630/548-6617
24600 West 127th Street; Plainfield, IL 60585 Phone: 630/646-2273 Fax: 630/548-6617
177 E. Brush Hill Road Elmhurst, IL 60126 Phone: 630/646-2273 Fax: 331/221-3887

Rituximab Biosimilar Infusion Orders

Patient Name: _____ DOB: _____

Please include current history and physical and any recent labs/tests, if applicable

PLEASE ATTACH COPY OF INSURANCE CARD WITH THIS ORDER

Pre-Authorization # or Call Reference #: _____
(Ordering Physician Office is Responsible to Obtain Authorization/Referral)

☐ **Check if insurance requires drug to be provided by specialty pharmacy**

Contact Name and Phone Number of Insurance Company: _____

If you have any questions regarding pre-authorizations, please contact (630) 646-2273 and ask for the billing department.

Diagnosis (ICD-10 Required): _____

Weight (lbs/kg): _____ Height: _____

Is this their first dose? ☐ Yes ☐ No Date of Previous Dose: _____

Pre-Infusion Requirements

This patient must have a current CBC/differential done within 48 hours of treatment.

Lab results to be faxed prior to treatment	☐ Yes	☐ No
Hepatitis B panel within the last 6 months	☐ Yes	☐ No
Draw CBC/differential at the Cancer Center Day of treatment.	☐ Yes	☐ No

Drug:
☐ Truxima ☐ Ruxience ☐ Riabni

Dose: _____ mg/m^2 = _____ mg

Frequency: _____

Rituximab and Biosimilar Infusion Orders

Pre-Medications: (Please mark all that apply)

☐ Tylenol 650mg po prior to infusion
☐ Benadryl 25mg IVP prior to infusion
☐ Benadryl 25mg po prior to infusion

In the event of a hypersensitivity reaction during the infusion of this medication, we will implement the reaction protocol. A designated nurse practitioner will evaluate your patient and your office will receive notification of the event.

In the event that your patient has a central line, it will be used per the Cancer Center protocol, unless otherwise directed.

Physician Signature: _____ **Date:** _____

Ordering Physician NPI: _____ **Swedish Hospital NPI:** **1831151257**

_____ _____ _____

Physician Name (Please Print) **Office Phone** **Fax Number**

Revision/Review Date: 12/2024