Atrium Health

Atrium Health Infusion Center

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390
	☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390
	☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

Rituximab or Biosimilar Infusion Order (Revised 11/11/2025)

All orders with a √ will be placed.

Patient Demographics:

Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:

Allergies: (please list all allergies or attach list)

☐ NKDA

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)

☐ M05._____ Rheumatoid Arthritis with rheumatoid factor	☐ M06._____ Rheumatoid Arthritis without rheumatoid factor
☐ M05.79 - Rheumatoid Arthritis with rheumatoid factor of multiple sites, without organ or systems involvement	☐ M31.30 - Granulomatosis with Polyangitis (GPA/Wegener's Granulomatosis)
☐ M31.7 - Microscopic Polyangitis (MPA)	☐ Other:

Required Documentation: (*required prior to scheduling*)

Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:
Complete Medication List - Include all tried and failed meds	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Treatment Parameters:

☑ Hold treatment and notify provider IF:
- Temperature is GREATER THAN 100oF;
- Patient complains of symptoms of acute viral or bacterial infection;
- Patient is taking an antibiotic for current infection.

☑ Required Lab Results: (**Fax labs with order**)
- Hep B Profile PRIOR to initial treatment;
- IgG PRIOR to initial treatment and then annually;
- CBC with diff within 90 days PRIOR to day 1 treatment.

☑ Hold Treatment and Notify Provider IF:
- Hep B Profile: POSITIVE result or not on file;
- Hemoglobin LESS THAN 9g/dL;
- ANC LESS THAN 700.

Nursing Communication:

☑ Start PIV/Access CVC and flush device per approved Atrium Health protocol.

☑ Obtain vital signs PRE-treatment, 30 minutes after initiation of treatment, hourly for the remainder of treatment, POST-treatment, and 30 minutes POST-treatment for the first 2 treatments then subsequent treatments PRN.

☑ Monitor patient for signs of reaction for 30mins after completion of first 2 infusions and subsequent infusions PRN if previous signs of reaction observed.

Pre-Medications: (Administer all pre-medications 30mins prior to treatment)

☐ Acetaminophen (Tylenol) 650mg PO ONCE

☐ Diphenhydramine (Benadryl) 25mg PO ONCE

☐ Diphenhydramine (Benadryl) 25mg IV ONCE

☐ Loratadine (Claritin) 10mg PO ONCE

☐ Methylprednisolone sodium succinate (Solu-Medrol) 125mg IV ONCE

Infusion Therapy:

☐ Rituximab or Biosimilar Infusion INITIAL dose(s):

☐ 1000mg IV Day 1 and Day 15	☐ 1000mg IV ONCE

☐ Rituximab or Biosimilar Infusion SUBSEQUENT doses:

☐ 1000mg IV Day 1 and Day 15 every 16 weeks	☐ 1000mg IV ONCE every 16 weeks
☐ 1000mg IV Day 1 and Day 15 every 20 weeks	☐ 1000mg IV ONCE every 20 weeks
☐ 1000mg IV Day 1 and Day 15 every 24 weeks	☐ 1000mg IV ONCE every 24 weeks

☐ Rituximab or Biosimilar Infusion

☐ 375mg/m2 IV once per week x 4 doses	Use this space for any additional dose or frequency: ☐

☑ **Atrium Health will authorize the payer preferred rituximab product**
Please list any contraindicated rituximab product:
Please list the reason for the contraindication:

Supportive Care Medications:

☑ Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.

☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.

☑ Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:

☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

Prescriber Information:

Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted

Signature:	Date: