

Pensacola  
41 Fairpoint Drive  
Suite B  
Gulf Breeze, FL 32561

Boca Raton  
9980 N Central Park Blvd  
Suite 202  
Boca Raton, FL 33428



**RIABNI<sup>®</sup>** (rituximab-arrx)

**ORDER FORM**

Date: \_\_\_\_\_

**PATIENT INFORMATION**

|                                          |        |                |                                                            |
|------------------------------------------|--------|----------------|------------------------------------------------------------|
| Name:                                    | Phone: | DOB:           | SEX: M <input type="checkbox"/> F <input type="checkbox"/> |
| <input type="checkbox"/> NKDA Allergies: |        | Weight lbs/kg: |                                                            |

**PHYSICIAN INFORMATION**

|                  |                      |                      |  |
|------------------|----------------------|----------------------|--|
| Physician Name*: | Practice Name:       |                      |  |
| Address:         | Office Contact Name: | Office Contact #:    |  |
| Phone:           | Fax:                 | Email (for updates): |  |

**REFERRAL STATUS**

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order

**RIABNI<sup>®</sup>** is indicated for the treatment of adult patients with:

- ☐ Relapsed or refractory, low-grade or follicular, CD20-positive, B-cell NHL as a single agent.
- ☐ Previously untreated follicular, CD20-positive, B-cell NHL in combination with first line chemotherapy and, in patients achieving a complete or partial response to a rituximab product in combination with chemotherapy, as single-agent maintenance therapy.
- ☐ Non-progressing (including stable disease), low-grade, CD20-positive, B-cell NHL as a single agent after first-line cyclophosphamide, vincristine, and prednisone (CVP) chemotherapy.
- ☐ Previously untreated diffuse large B-cell, CD20-positive NHL in combination with cyclophosphamide, doxorubicin, vincristine, prednisone (CHOP) or other anthracycline-based chemotherapy regimens.

- ☐ ICD-10\*: \_\_\_\_\_
- ☐ Dx Code: \_\_\_\_\_
- ☐ Dx Code: \_\_\_\_\_

**PRE-MEDICATION**

- ☐ Tylenol PO 650mg ☐ 1000 MG ☐ other \_\_\_\_\_
- ☐ Solumedrol 125mg IV ☐ other \_\_\_\_\_
- ☐ Benadryl ☐ 25mg ☐ 50mg ☐ other \_\_\_\_\_ ☐ IV ☐ PO
- ☐ Benadryl 50 mg ☐ or PO
- ☐ Medication \_\_\_\_\_ Dose \_\_\_\_\_ Route \_\_\_\_\_
- ☐ \_\_\_\_\_ (other) ☐ \_\_\_\_\_ (other)

PREMEDICATING WITH AN ANTIHISTAMINE AND ACETAMINOPHEN  
For RA, GPA and MPA patients, methylprednisolone 100 mg intravenously or its equivalent is recommended 30 minutes prior to each infusion.

**DOSAGE FORMS AND STRENGTHS:**

Injection: 100 mg/10 mL (10 mg/mL) and 500 mg/50 mL (10 mg/mL) solution in single-dose vials (3)

**FREQUENCY**

- ☐ Date of last dose: \_\_\_\_\_

**DOSING AND INDICATION**

B-cell NHL is 375 mg/m<sup>2</sup>

- ☐ CLL is 375 mg/m<sup>2</sup> in the first cycle and 500 mg/m<sup>2</sup> in cycles 2-6, in combination with FC, administered every 28 days X \_\_\_\_\_ months.
- ☐ RA in combination with methotrexate is two-1,000 mg intravenous infusions separated by 2 weeks (one course) every 24 weeks or based on clinical evaluation, but not sooner than every 16 weeks. Methylprednisolone 100 mg intravenous or equivalent glucocorticoid is recommended 30 minutes prior to each infusion.
- ☐ For adult patients with active GPA and MPA in combination with glucocorticoids is 375 mg/m<sup>2</sup> once weekly for 4 weeks.
- ☐ The follow up dose for adult patients with GPA and MPA who have achieved disease control with induction treatment, in combination with glucocorticoids is two 500 mg intravenous infusions separated by two weeks, followed by a 500 mg intravenous infusion every 6 months thereafter based on clinical evaluation.

**WARNINGS AND PRECAUTIONS**

[https://www.pi.amgen.com/-/media/Project/Amgen/Repository/pi-amgen-com/Riabni/riabni\\_pi\\_english.pdf](https://www.pi.amgen.com/-/media/Project/Amgen/Repository/pi-amgen-com/Riabni/riabni_pi_english.pdf)

**REQUIRED DOCUMENTATION CHECKLIST:**

- \_\_\_\_ Patient Demographics
- \_\_\_\_ Insurance Card/Information
- \_\_\_\_ Recent labs to include CBC w/diff + Plts, CMP, HBsAg and anti-HBc before initiating treatment with RIABNI (rituximab-arrx) and please send any other recent labs
- \_\_\_\_ Recent Progress and Vaccination Status
- \_\_\_\_ Other

**ORDERING PROVIDER**

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

NPI \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_