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Westerville, Ohio 43081

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

Lancaster
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

RIABNI® (rituximab-arrx) ORDER FORM

Date: _____

PATIENT INFORMATION

Name:	*Phone:*	*DOB:* *SEX: M* ☐ *F* ☐
☐ *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:* 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/m2

☐ ***CLL is 375 mg/m2 in the first cycle and 500 mg/m2 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/m2 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/Repositorypi-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 Progres and Vaccination Status***
_____ ***Other***

ORDERING PROVIDER

Signature **X** _____ *Date* _____ NPI_____

Provider _____ *Phone* _____ Fax _____