

Rituxan

Ruxience, Truxima



InfusionForHealth.com

Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order.

Required Labs: CBC and Hep B

List types of drugs/common drugs for tried/failed for prescribed med:

PATIENT INFORMATION

PRESCRIBER INFORMATION

Patient Name: _____

Prescriber's Name: _____

Patient Contact Number: _____

Signature: _____

DOB: _____

NPI: _____ Date: _____

Allergies: _____

Phone: _____ Fax: _____

Weight: _____ lbs / kg Height: _____

Office Address: _____

Diagnosis: C85.90 C91.10 C91.11 M06.9 M31.3

Contact Person: _____

M31.7 L10.0 Other Dx/ICD10: _____

Contact Email: _____

The following medications will be administered per prescribing information:

Center will use Hypersensitivity protocol established by Infusion for Health and P.I.

- | | | | | | | |
|---|--------------------------------|--------------------------------|--------------------------------|-----------------------------|--------------------------------------|------------------------------|
| <input type="checkbox"/> Diphenhydramine | <input type="checkbox"/> 25mg | <input type="checkbox"/> 50mg | <input type="checkbox"/> PO | <input type="checkbox"/> IV | <input type="checkbox"/> Other _____ | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> 325mg | <input type="checkbox"/> 500mg | <input type="checkbox"/> 650mg | PO | <input type="checkbox"/> Other _____ | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Methylprednisolone | <input type="checkbox"/> 40mg | <input type="checkbox"/> 125mg | | IV | <input type="checkbox"/> Other _____ | <input type="checkbox"/> N/A |

RITUXIMAB IV DOSAGE

Date of Last Treatment, If Continuation: _____

Dose: _____ **Frequency:** _____

Route: IV

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.

Lab Orders: CBC with platelets, Hep B Prior to first appointment Other Frequency: _____

Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.