

Rituxan

(Or other rituximab products as required by the patient's health plan)



Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:

Patient Demographics; Insurance Information; All Clinical Documentation Supporting the Diagnosis Including Any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing; Recent Labs (CBC w/ diff & platelets and Hep B)

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): M05. _____ M06. _____ M31.30 M31.31 M31.7 L10.0 Other _____

ICD Description: _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

- Deliver patient care in accordance with Infusion for Health clinical procedures and the medication's prescribing information (PI), including management of hypersensitivity reactions
- Hep B (HBsAg and anti-HBc) Test Results
- CBC with diff and platelets

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- 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.

PRE-MEDICATION ORDERS

It is recommended to premedicate patients with acetaminophen, an antihistamine, and methylprednisolone (or equivalent corticosteroid) 30 minutes prior to each infusion.

- Diphenhydramine 25mg / 50mg PO / IV
 - Acetaminophen 325mg / 500mg / 650mg PO
 - Methylprednisolone 40mg / 125mg IV
 - Other: _____
- Dose: _____ Route: _____ Frequency: _____

For RA patients, it is recommended that Rituxan be given in combination with Methotrexate.

SPECIAL INSTRUCTIONS:

THERAPY ADMINISTRATION

- Rituxumab Intravenous Infusion
Dose: 500mg 1,000mg Other: _____
Frequency: _____
 On Day 0 and Day 14; repeat every _____ weeks.
 Other _____
- Refills: Zero / for 12 months / _____
(if not indicated, order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must *handwrite* "Brand Medically Necessary" on the prescription form. If not indicated, 14H is authorized to administer a generic or biosimilar.

Provider Name (Print) _____ Provider Signature _____ Date _____

- 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.