



# Rituxan (Rituximab)

INFUSION THERAPY CENTERS

New Referral     Restart     Medication Order Change

## PATIENT INFORMATION

Name \_\_\_\_\_  
Date \_\_\_\_\_  
DOB \_\_\_\_\_  
SS# \_\_\_\_\_  
Phone # \_\_\_\_\_  
Email \_\_\_\_\_

## PHYSICIAN INFORMATION

Referring Physician \_\_\_\_\_  
Practice Address \_\_\_\_\_  
Office Contact Name \_\_\_\_\_  
Contact Phone # \_\_\_\_\_ Fax # \_\_\_\_\_  
NPI / TIN \_\_\_\_\_

## MEDICATION ORDERS

Patient Weight: \_\_\_\_\_ kg     Initial/Reload Dosing: \_\_\_\_\_ 1000mg IV on day 0, day 14, then repeat the course every \_\_\_\_\_ weeks.  
 Other Dosing: \_\_\_\_\_ mg/m<sup>2</sup> IV every week for 4 weeks.

Premeds:     diphenhydramine     APAP     IV methylprednisolone 100mg     IV methylprednisolone 1000mg

Indication / Diagnosis:

- M05.79 Rheumatoid arthritis with rheumatoid factor without organ or systems involvement
- M06.9 Rheumatoid arthritis, unspecified
- G36.0 Neuromyelitis Optica
- Other (*please specify in additional information*)

Additional Information:

ICD-10 (Required) \_\_\_\_\_

MD Signature \_\_\_\_\_ Date \_\_\_\_\_

## REQUIRED DOCUMENTATION

Please send the following documents and records. This will help streamline the pre-authorization process.

- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- If this is a continuation of a treatment, include the last infusion note
- Current medication list

Most recent diagnostics results to include:

- Chest Xray
- CBC with differential
- TB test (within 12 months)
- Hepatitis B-Core Ab, B SAg, B SAb
- Comprehensive metabolic panel
- COCCI
- Hepatitis C-Ab

*We will contact the patient and schedule their infusion appointment once we have the insurance pre-authorization completed.*

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