Patient Name
DOB
Cell Phone
Address

RITUXIMAB (Rituxan & biosimilars)

Status	☐ New Therapy ☐ Order Renewal ☐ Dosage or Frequency Change
Diagnosis	☐ ICD 10: M05.___ or M06.___ Rheumatoid Arthritis (RA) ☐ ICD 10 Code: ______ Other: ________________________
Pertinent Medical Hx	Patient's weight (most recent): ___________ lbs / kg (circle one) Date: _______ Have Hepatitis B Serologies been completed? (Provide documentation) ☐ Y ☐ N Is patient currently taking Methotrexate? ☐ Y ☐ N
Labs	Labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician If Infusion Clinic: __________________________
Premeds	☐ No premeds necessary ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO ☐ cetirizine (Zyrtec) 10mg PO - ***OR*** - ☐ diphenhydramine (Benadryl) 25mg IV ☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV ☐ other: ___________
IV Fluids	☐ NS TKO ☐ Other: ____________
Medication Order	Drug: ☐ Biosimilar or originator product, based on payer preference or Infusion Clinic preference (*preferred*) - ***OR*** - ☐ Specific product: ________________ ☐ 1000mg IV on Day 1 and Day 15 every ______ months ☐ Other: _______________
Monitoring	Monitor for signs/symptoms of hypersensitivity during infusion and 30 mins post-infusion. For any signs of infusion reaction: STOP infusion. Contact on-site provider for instruction.
Additional Orders	
Physician Information	Physician Name ______________________ NPI _____________ Office Contact ______________________ Phone _____________ **Provider Signature:** ______________________ Date _____________

REQUIRED DOCUMENTATION

o Patient Demographics & **Insurance** Information:	– Copy of patient's insurance card – front and back
o **Clinical / Progress Notes**, supporting primary diagnosis:	– 2 most recent office notes – Medication history
o Most Recent **Labs**:	– CMP and CBC – Hep B serology results (HBsAg, anti-HBc)

FAX to (480) 400-6121
Intake Specialist (480) 927-3800
referral@infuseablecare.com