Please fax completed form, insurance card, and clinical documentation to:
**FAX: 410-220-2553**

## RITUXIMAB ORDER RA

☐ **New Start** ☐ **Maintenance: Last Dose Given**_____________

| Referring Office: | Contact Name: | Date: |
|---|---|---|
| Direct Phone for Contact: | Fax: | |
| Patient Name: | DOB: | |

Allergies ☐ NKDA ☐ Allergies:

_______________________________________________________ Height:

_______________________ Weight: ________________

**Indication:**
☐ M05.___ RA with Rheumatoid Factor
☐ M06.___ RA w/o Rheumatoid Factor
☐ Other ___________________________________________________________________________

**DRUG:** Rituxan | Truxima | Riabni | Ruxience
☐ Rituximab-per insurance preferred
☐ Rituxan
☐ Truxima (rituximab-abbs)
☐ Riabni (rituximab-arrx)
☐ Ruxience (rituximab-pvvr)

**DOSE**
☐ 1000mg
☐ Other _______

**FREQUENCY**
☐ At days 0 and 15(approximately)
☐ At days 0 and 15(approximately) every_____months ☐ Other_____________

**PREMEDICATION ORDERS:** *antihistamine, acetaminophen and 100mg methylprednisolone are recommended in the PI* ☐ Acetaminophen po: ☐ 1000mg ☐500mg 30 min prior to infusion.
☐ Diphenhydramine: ☐ 25mg PO ☐ 50mg PO ☐ 25mg IVP 30 min prior to infusion.
☐ Solu-Medrol: ☐ 62.5mg IVP ☐ 100mg IVP ☐ Other______ 30 min prior to infusion.
☐ Other ____________________________________________________________________

| Prescriber Name: Title: | |
| --- | --- |
| NPI: | DEA: |
| Prescriber Signature: Date of Order: | |

**Referrals will not be processed until we receive ALL the following:**

☐ Face Sheet / Patient Demographics

☐ Insurance card(s) – copy of front & back

☐ Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:

☐ CBC ☐ CMP ☐ Lipids ☐ TB ☐ Hep B Other: ______________________________________________