



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 _____

<p>DRUG: Rituxan Truxima Riabni Ruxience</p> <p><input type="checkbox"/> Rituximab-per insurance preferred</p> <p><input type="checkbox"/> Rituxan</p> <p><input type="checkbox"/> Truxima (rituximab-abbs)</p> <p><input type="checkbox"/> Riabni (rituximab-arrx)</p> <p><input type="checkbox"/> Ruxience (rituximab-pvvr)</p>	<p>DOSE</p> <p><input type="checkbox"/> 1000mg</p> <p><input type="checkbox"/> Other _____</p> <p>FREQUENCY</p> <p><input type="checkbox"/> At days 0 and 15(approximately)</p> <p><input type="checkbox"/> At days 0 and 15(approximately) every _____ months <input type="checkbox"/> Other _____</p>
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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: _____