InfuCare Rx

Rituxan® Referral Form

of Pages Faxed: _____
Fax Referral To: 877-828-3941
Phone: 877-828-3940

Date Required: _____ Ship To: ☐ Home ☐ Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Alternate Phone: _____
Date of Birth: _____ Gender: ☐ Male ☐ Female

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
Secondary Insurance: _____ ID: _____ Group: _____
Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS

☐ C85.90 Non-Hodgkin's Lymphoma
☐ C91.0 Chronic Lymphocytic Leukemia (not in remission)
☐ C91.1 Chronic Lymphocytic Leukemia (remission)
☐ C91.2 Chronic Lymphocytic Leukemia (relapse)
☐ M06.9 Rheumatoid Arthritis
☐ M31.30 Granulomatosis With Polyangiitis
☐ G31.7 Microscopic Polyangiitis
☐ L10.1 Pemphigus Vulgaris
☐ Other: _____

PATIENT EVALUATION

Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
Allergies: _____
BSA: _____
Tuberculin (PPD) skin test date: _____ ☐ Neg ☐ Pos
HepB surface antigen: ☐ Neg ☐ Pos
Hepatitis B vaccination administered: ☐ Yes ☐ No Date: _____
Initial LFTs normal: ☐ Yes ☐ No
History of CHF: ☐ Yes ☐ No
Date of first lifetime dose of Rituximab: _____
Date of last dose of Rituximab: _____
Standing Lab orders: ☐ CMP ☐ CBC ☐ ESR ☐ CRP
☐ Other: _____ Frequency: _____
Therapy Start Date: _____ Therapy End Date: _____
Nursing Coordination:
☐ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication:	Strength:	Dose and Directions:	Quantity:	Refills:
RITUXAN® (Rituximab)	☐ 100mg vial ☐ 500mg vial	☐ Rituxan 1000mg IV every 14 days for two doses ☐ Repeat in 6 months ☐ Rituxan 375 mg/m² IV every _____ ☐ Other: _____		

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol
☐ NaCl 0.9% 10mL

Pre-Medications & Other Medications
☐ Acetaminophen 650 mg PO 30-60 min prior to infusion
☐ Diphenhydramine 25 mg PO 30-60 min prior to infusion
☐ Methylprednisolone 100 mg slow IV push 30 min prior to infusion
☐ Other: _____

☐ Infusion supplies as per protocol
☐ Anaphylaxis Kit orders as per protocol

Please Include Documented Progression Of Disease/Prior Therapies For Justification For The Drug:

Prescriber Signature: _____ **Date:** _____