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
☐ G70.00 Myasthenia Gravis
☐ 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:**_____