

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)	<input type="checkbox"/> 100mg vial <input type="checkbox"/> 500mg vial	<input type="checkbox"/> Rituxan 1000mg IV every 14 days for two doses <input type="checkbox"/> Repeat in 6 months <input type="checkbox"/> Rituxan 375 mg per m <sup>2</sup> IV every _____ <input type="checkbox"/> Other: _____		

**PREMEDICATION ORDERS/OTHER MEDICATIONS**

<b>Flush Protocol</b> <input type="checkbox"/> NaCl 0.9% 10mL	<b>Pre-Medications &amp; Other Medications</b> <input type="checkbox"/> Acetaminophen 650 mg PO 30-60 min prior to infusion <input type="checkbox"/> Diphenhydramine 25 mg PO 30-60 min prior to infusion <input type="checkbox"/> Methylprednisolone 100 mg slow IV push 30 min prior to infusion <input type="checkbox"/> Other: _____	<input type="checkbox"/> Infusion supplies as per protocol <input type="checkbox"/> Anaphylaxis Kit orders as per protocol
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**Please Include Documented Progression Of Disease/Prior Therapies For Justification For The Drug:**

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Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_