

 Please cut along the dotted lines before submitting to a pharmacy.

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

PATIENT INFORMATION

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Date of Birth: _____ Gender: _____
 Emergency Contact: _____ Phone: _____

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 ² IV every _____ <input type="checkbox"/> Other: _____		

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol <input type="checkbox"/> NaCl 0.9% 10mL	Premedications & Other Medications <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:

Prescriber Signature: _____ Date: _____