

✂ 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) | 100mg vial<br>500mg vial | Rituxan 1000mg IV every 14 days for two doses<br>Repeat in 6 months<br>Rituxan 375 mg per m <sup>2</sup> IV every _____<br>Other: _____ |           |          |

**PREMEDICATION ORDERS/OTHER MEDICATIONS**

| Flush Protocol | Premedications & Other Medications   |
|----------------|--|
| NaCl 0.9% 10mL | Acetaminophen 650 mg PO 30-60 min prior to infusion<br>Diphenhydramine 25 mg PO 30-60 min prior to infusion<br>Methylprednisolone 100 mg slow IV push 30 min prior to infusion<br>Other: _____ |

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

\_\_\_\_\_

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