Rituximab (Rituxan)

MIC | METRO INFUSION CENTER

REFERRAL STATUS: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:		DOB:
☐ NKDA Allergies:		Weight (lbs / kg):	Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy - Last Treatment Date:			Next Due Date:

PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		

DIAGNOSIS AND ICD 10 CODE	
☐ Rheumatoid Arthritis (RA)	☐ ICD 10 Code: M06.9
☐ Chronic Lymphocytic Leukemia (CLL)	☐ ICD 10 Code: C91.10
☐ Other Diagnosis:	☐ ICD 10 Code:

REQUIRED DOCUMENTATION/Testing	
☐ This signed order form by the provider	☐ Labs and Tests supporting primary diagnosis
☐ Patient demographics AND insurance info	☐ Hepatitis B Test Results: HBsAg & Total HepB Core Antibody
☐ Clinical/Progress notes supporting primary dx	
List Tried & Failed Therapies 1)	2)

PREMEDICATION ORDERS

☐ acetaminophen (Tylenol) PO ☐ 500mg ☐ 650mg ☐ 1000mg

☐ diphenhydramine (Benadryl) **PO / IV** ☐ 25mg ☐ 50mg (if route is not circled PO will be administered)

☐ methylprednisolone (Solu-Medrol) IV ☐100mg ☐ 125mg ☐ _____ mg

☐ Other:

MEDICATION ORDERS

Please check box ☐ if ok to substitute with a rituximab biosimilar per insurance preferred product

☐ Rituxan 1000mg IV every 14 days for two doses ONLY

☐ Rituxan 1000mg IV every 14 days for two doses; Repeat every 6 months

☐ Rituxan 1000mg IV once ☐ Rituxan 375 mg/m² IV every _____

☐ Other: Rituxan _____IV _____

Refills*: ☐ None ☐ X6 months ☐ X1 year ☐ Other: _____

**(if not indicated order will expire one year from date signed)*

SPECIAL INSTRUCTIONS

Provider Name (Print) **Physician Signature:** **Date:**

Fax referral to 866-507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

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