Rituxan

Rituximab

(Or other rituximab products as required by the patient's health plan)

INFUSE ONE OHIO

Treatment Location: ☐ Dublin, OH ☐ Lancaster, OH

PROVIDERS: Please include the following to expedite the order:
Patient Demographics; Insurance Information; All Clinical Documentation Supporting the Diagnosis Including Any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing; Recent Labs (CBC w/ diff & platelets and Hep B)

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ M05._____ ☐ M06._____ ☐ M31.30 ☐ M31.31 ☐ M31.7 ☐ L10.0 ☐ Other _____

ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

☑ Center will use hypersensitivity protocol established by Infuse One Ohio

☑ Hep B (HBsAg and anti-HBc) Test Results

☑ CBC with diff and platelets

PRE-MEDICATION ORDERS

It is recommended to premedicate patients with acetaminophen, an antihistamine, and methylprednisolone (or equivalent corticosteroid) 30 minutes prior to each infusion.

☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO

☐ Methylprednisolone ☐ 40mg / ☐ 125mg IV

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

For RA patients, it is recommended that Rituxan be given in combination with Methotrexate.

SPECIAL INSTRUCTIONS:

THERAPY ADMINISTRATION

☑ Rituxumab Intravenous Infusion

Dose: ☐ **500mg** ☐ **1,000mg** ☐ **Other:** _____

Frequency:

☐ **On Day 0 and Day 14; repeat every** ____ **weeks.**

☐ **Other** _____

☑ Refills: ☐ Zero / ☐ for 12 months / ☐ _____

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

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Infuse One Ohio is authorized to administer a generic or biosimilar.

Provider Name (Print) Provider Signature Date

☐ *Please check this box if you DO NOT authorize Infuse One Ohio to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.*