

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.