



Rx Order Form - Rituximab

Fax Form to (626) 999-3236

Patient Information		Prescriber Information		
Patient Name: _____		Prescriber Name: _____		
Address: _____		Address: _____		
City, State, Zip: _____		City, State, Zip: _____		
Home Phone: _____		Phone: _____ Fax: _____		
Cell Phone: _____		DEA: _____ NPI #: _____		
DOB: _____ Gender: ☐ M ☐ F		Contact Person: _____		
Allergies ☐ NKDA ☐ Specify: _____				
Insurance Information (Please fax a copy of the front and back of all cards)				
Primary Insurance: _____		ID#: _____	Group: _____	
Secondary Insurance: _____		ID#: _____	Group: _____	
Prescription Card: _____	ID#: _____	BIN#: _____	PCN#: _____	Group: _____
Diagnosis (ICD-10) (please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization)				
☐ 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: _____
Premedication				
Premedication can be given 30-60 minutes prior to infusion:				
☐ Acetaminophen PO: ☐ 325mg ☐ 500mg ☐ 650mg				
☐ Diphenhydramine: ☐ 25mg IV ☐ 50mg IV ☐ 25mg PO ☐ 50mg PO, or ☐ Alternate oral antihistamine: _____				
☐ Cetirizine 10mg ☐ Loratadine 10mg. _____				
☐ Methylprednisolone ☐ 125mg IV ☐ 40mg IV or ☐ _____mg PO; ☐ Fexofenadine 60mg, or ☐ 180mg				
☐ Others/Miscellaneous: _____				
☐ Epinephrine pen Auto-injector 2 pack 0.3mg/0.3ml IM as needed for anaphylaxis.				
Medication	Strength	Directions	Quantity	Refills
Rituximab 10mg/ml	☐ 100mg vial ☐ 500mg vial	☐ Rituxan 1000mg IV every 14 days for two doses. ☐ Repeat in 6 months. ☐ Rituxan 375 mg per m ² IV every: _____ ☐ Other: _____		
Flushing Protocol:				
☐ NaCl 0.9% 5-10ml IV before and after infusion				
☐ Heparin 100 units/ml 3-5ml IV after infusion for Port IV access and PRN				
☐ All infusion supplies necessary to administer the medication				
*Skilled Nurse to assess, teach, and administer prescribed medication and admit for services.				
By signing below, I certify that the above therapy is medically necessary and Substitution with biosimilar is authorized unless noted otherwise.				
_____ Provider Signature		_____ Date	_____ Notes	

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