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
☐ Diphenydramine: ☐ 25mg IVP ☐ 50mg IVP ☐ 25mg PO ☐ 50mg PO, or ☐ Alternate oral antihistamine:
☐ Cetirizine 10mg ☐ Loratadine 10mg _____.
☐ Methylprednisolone ☐ 125mg IVP ☐ 40mg IVP 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

120 N Fairway Ln Ste A, West Covina, CA 91791 | Ph: 626-999-3636 | Fax: 626-999-3236