

Rituxan Biosimilar Referral Form



PHONE: 1-800-277-7302 FAX: 1-866-374-6663

Demographics Information: Today's Date _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: GA Zip: _____

Phone #: _____ Cell Alternate Phone #: _____ Cell

Height: _____ in/ft **Weight:** _____ lbs/kg Date weight recorded: _____ **Last 4 of SSN:** _____

Allergies: _____ NKDA

Diagnosis Information:

Rheumatoid Arthritis M05.79 Other Diagnosis/ICD10Code _____

Date Infusion to Begin: _____	Is this a first infusion? <input type="checkbox"/> YES <input type="checkbox"/> NO
Previous Infusion Reaction: <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of Last Infusion: _____
List Reactions: _____	List of Failed Therapies: _____

Assessment Questions: *Please Provide Appropriate Documentation*

Diabetes? Yes No HTN? Yes No Cardiac History? Yes No Difficulty Breathing? Yes No

Requires Oxygen? Yes No Confusion /Disorientation? Yes No Neuro History? Yes No

TB status if known: _____ **Date of Hep B Core and HBsAg:** _____

Ruxience®(rituximab-pvvr)Q5119 **Truxima®(rituximab-abbs)Q5115** **Riabni®(rituximab-arrx)J3490**

Is patient also taking methotrexate? Yes No If not, please explain _____ Insurance to Dictate

Dose :1000mg given IV at 0 and 2 weeks then every 24 weeks from day 0 for ____ months. Titrate per IVCO policy. Nurse to Administer Methylprednisolone 100mg IV x1 30 minutes prior to infusion.

Alternate dosing: _____ mg given IV every _____ weeks for _____ months. Titrate per IVCO policy. Nurse to Administer Methylprednisolone 100mg IV x1 30 minutes prior to infusion.

Pre-Medications: Patient to Provide and take 30 minutes prior to infusion

Benadryl 25 MG PO x1 Benadryl 50 mg PO x1

Acetaminophen 325 mg PO x1 Acetaminophen 650 mg PO x1

Other Pre-medication: _____

Access: PIV PORT PICC **Route:** IV

Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency

PIV – NS 5mL: Qty 4

PORT – NS 10ml: Qty 4, Heparin 5mL 100units/mL x 1 per infusion.

PICC – NS 10mL: Qty 4, Heparin 5mL 10units/mL x 1 per infusion

Supplies: (please strike through if not required)

Administration Supplies (A4222) – 2 per infusion

Catheter Care Supplies (A4221) – 1 per week

Infusion Pump (E0781)

Nursing services to administer

For insurance compliance, the prescribing physician or PA must sign, no stamps or nurse/NP signatures

Physician/PA signature: _____

NPI # _____ Phone Number _____

Office Address: _____ City: _____ St _____ Zip: _____

Printed Name: _____ Contact Name: _____

Please fax this form to our Intake Department along with a copy of Patient's Insurance Card, Demographic information, H & P, Office Visit notes - including supporting documentation for failed therapies, and Up to Date Medication List.

1/22 TSP