



# Rituximab

### Select location:

|                        |                           |                    |                      |
|------------------------|---------------------------|--------------------|----------------------|
| Akron                  | Cleveland (Mayfield)      | Dayton (Englewood) | Springfield          |
| Anderson               | Cleveland (North Olmsted) | Findlay            | Toledo               |
| Athens                 | Columbus (East Broad)     | Liberty            | Troy                 |
| Canton                 | Columbus (Hilliard)       | Mansfield          | Warren               |
| Cincinnati (Blue Ash)  | Columbus (Worthington)    | Mentor             | Youngstown           |
| Cincinnati (West Side) | Dayton (Beavercreek)      | Perrysburg         | Zanesville           |
|                        |                           | Sandusky           | Crestview Hills (KY) |

**For new referrals, please include recent labs and last two office visit notes.**

**Fax completed form to 888-977-0914**

Phone: 877-787-8720 • www.horizoninfusions.com

### 1. PATIENT INFORMATION

|   |                       |                           |  |
|---|-----------------------|---------------------------|--|
| <b>Name:</b> _____  |                       | <b>DOB:</b> _____         |  |
| <b>Phone:</b> _____   |                       | <b>Other Phone:</b> _____ |  |
| <b>Email:</b> _____   |                       |                           |  |
| <b>Social Security #:</b> _____   |                       | <b>Allergies:</b> _____   |  |
| <b>Gender:</b> M F  | <b>Weight:</b> Lbs Kg |                           |  |
| <b>Patient Status:</b> New to therapy Continuing therapy Next due date (if applicable): _____ |                       |                           |  |

### 2. INSURANCE INFORMATION (required)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

### 3. PHYSICIAN INFORMATION

|                              |                    |                          |                  |
|------------------------------|--------------------|--------------------------|------------------|
| <b>Physician Name:</b> _____ |                    | <b>NPI#:</b> _____       |                  |
| <b>License #:</b> _____      | <b>TIN#:</b> _____ | <b>DEA#:</b> _____       |                  |
| <b>Address:</b> _____        |                    |                          |                  |
| <b>City:</b> _____           |                    | <b>State</b> _____       | <b>Zip</b> _____ |
| <b>Office Contact:</b> _____ |                    | <b>Email:</b> _____      |                  |
| <b>Office phone:</b> _____   |                    | <b>Office fax:</b> _____ |                  |

### 4. DIAGNOSIS INFORMATION (ICD 10 Code Required)

**\*Labs: Hep B required prior to initial infusion**

|   |                                       |              |
|---|---------------------------------------|--------------|
| Rheumatoid Arthritis (_____)                  | Pemphigus Vulgaris (PV) (_____)       |              |
| Granulomatosis with Polyangitis (GPA) (_____) | Microscopic Polyangitis (MPA) (_____) | Other: _____ |

### 5. PRESCRIPTION INFORMATION (requires new order every 12 months)

Use preferred Rituximab per payer recommendations

|   |                            |       |
|---|----------------------------|-------|
| <b>Product name:</b> _____                  | _____                      | _____ |
| <i>To be completed by Horizon Infusions</i> | Horizon Clinical Signature | Dated |

**Initial Maintenance**

Administer 1000mg at Day 1 and Day 15; Repeat every \_\_\_\_\_ weeks

First infusion in series: 50mg/hr, increasing every 30 minutes by 50mg/hr to maximum of 400mg/hr

Subsequent infusion in series: 100mg/hr, increasing every 30 minutes by 100mg/hr to maximum of 400mg/hr

Vital signs per HI protocol

Anaphylaxis & Hydration Management per HI protocol

**PRE-MEDICATIONS N/A**

Acetaminophen 500mg 650mg 1000mg

Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)

Diphenhydramine (Benadryl) 25mg 50mg

PO IV (requires driver)

Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV

Prednisone \_\_\_\_\_ mg PO

Other \_\_\_\_\_

**POST-MEDICATIONS N/A**

Acetaminophen 500mg 650mg 1000mg

Prednisone \_\_\_\_\_ mg PO

Other \_\_\_\_\_

### 6. LABS

|   |               |                                  |
|---|---------------|----------------------------------|
| CBC w/Diff  | Each Infusion | Other Frequency (specify): _____ |
| CRP   | Each Infusion | Other Frequency (specify): _____ |
| CMP   | Each Infusion | Other Frequency (specify): _____ |
| ESR   | Each Infusion | Other Frequency (specify): _____ |
| Hepatic Panel   | Each Infusion | Other Frequency (specify): _____ |
| Renal Panel   | Each Infusion | Other Frequency (specify): _____ |
| Quantiferon TB Gold, annually, last completed (date): _____ |               |                                  |
| Other (specify): _____                                      |               |                                  |

### 7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE