

Rituximab



Patient Status: ☐ NEW* ☐ CONTINUING

Next Due Date (if applicable) _____ Choose Location _____

*Include recent labs and last 2 office visit notes

Name _____ DOB _____

Phone _____ Other Phone _____

Email _____ SSN _____

Allergies _____ Weight _____ ☐ LBS ☐ Kg Gender ☐ M ☐ F

INSURANCE INFORMATION (Required)

Submit copies of the front and back of primary and/or secondary insurance cards with this referral

Physician Name _____ NPI# _____

License # _____ TIN# _____ DEA# _____

Address _____

City _____ State _____ Zip _____

Office Contact _____ Email _____

Phone _____ Fax _____

DIAGNOSIS INFORMATION:

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

- ☐ Rheumatoid Arthritis _____
☐ Granulomatosis with Polyangitis (GPA) _____

- ☐ Pemphigus Vulgaris (PV) _____ ☐ Other: _____
☐ Microscopic Polyangitis (MPA) _____

DOSING

☐ Use preferred Rituximab per payer recommendations

☐ Product name: _____
To be completed by Horizon Infusions

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 _____

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): _____

Provider Signature _____

Date _____

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

Fax Referrals to: Kentucky (888) 977-0914 | New York (315) 457-4305 | Ohio (888) 977-0914 | Pennsylvania (724) 240-1586