



# Rituximab

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

Fax completed form to (315) 457-4305

Phone (315) 457-3091

### 1. PATIENT INFORMATION

Name:	DOB:
Phone:	Other Phone:
Email:	
Social Security #:	Allergies:
Gender: M F	Weight: Lbs Kg
Patient Status: 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

Physician Name:	NPI#:
License #: TIN#:	DEA#:
Address:	
City:	State Zip
Office Contact:	Email:
Office phone:	Office fax:

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

\*Labs: Hep B required prior to initial infusion

Rheumatoid Arthritis (_____)	Pemphigus Vulgaris (PV) (_____)
Granulomatosis with Polyangiitis (GPA) (_____)	Microscopic Polyangiitis (MPA) (_____)
Other: _____	

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

Use preferred Rituximab per payer recommendations

Product name: _____	_____	_____
<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