



Rituximab

Select location:

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

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 Polyangitis (GPA) (_____)	Microscopic Polyangitis (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 _____