Horizon Infusions

Rituximab

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

Fax completed form to (724) 240-1586
Phone (724) 510-3702

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: _____

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 _____

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