Rituxan®
Rituximab

Horizon Infusions

Location
- ☐ Camillus
- ☐ Liverpool
- ☐ New Hartford

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

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

☐ RITUXAN ☐ RUXIENCE ☐ TRUXIMA ☐ RIABNI

☐ 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)
- ☐ Diphenhydrimine (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**