



PATIENT INFORMATION

Demographics attached

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

J Code: J9312

Patient Weight: _____ lbs. Allergies: _____

- Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached
 Required Labs: CBC w/ platelet, Hepatitis B antigen, Hepatitis B core total antibody
 Recommended Labs: Quantitative immunoglobulins (IgM, IgG, and IgA), Hepatitis C Virus, TB Test

Labs: Required labs to be drawn by: Infusion Clinic Referring Physician

Lab Orders: _____

RITUXIMAB ORDERS

SELECT BRAND: RITUXAN TRUXIMA RUXIENCE

Diagnosis: Rheumatoid Arthritis (ICD-10 _____) Other: _____ (ICD-10 _____)
 (RA) **Dose:** 1000mg **Dose Frequency:** Day 0, repeat dose in 2 weeks
 One time dose

Diagnosis: Granulomatosis w/ Polyangiitis (ICD-10 _____) Microscopic Polyangiitis (ICD-10 _____)
 (GPS/MPA) **Dose:** 375mg/m2 - **Dose Frequency:** weekly x 4 weeks Other: _____
 500mg - **Dose Frequency:** Day 0, repeat dose in 2 weeks Other: _____

Diagnosis: Pemphigus Vulgaris (ICD-10 _____)
 (PV) **Dose:** Initial Dose: 1000mg IV **Dose Frequency:** Day 0, repeat dose in 2 weeks
 Maintenance Dosing: 500mg IV Every 6 months

Diagnosis: Other: _____ (ICD-10 _____)
 (Other) Other: _____ (ICD-10 _____)
Dose: 1000mg 500mg 375mg/m2 Other: _____
Dose Frequency: One Dose Day 0, repeat dose in 2 weeks Other: _____

Protocol Pre-Medication: Solu-Medrol 100mg IV, Tylenol 1000mg PO, Benadryl 50mg PO/IV
 Other: _____

Order Frequency: One time order, no refills
 Repeat ordered dose every _____ week(s) **OR** _____ month(s) **X** _____ dose(s)

Additional Orders/Comments:

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____
 Phone: _____ Fax: _____ Contact Person: _____