AYSA
THERAPEUTICS INFUSION

RITUXAN (RITUXIMAB) ORDER FORM

P: 470.395.6076 | F: 470.745.0716

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: ______________________________

RITUXAN ORDERS

Diagnosis: (RA) ☐ Rheumatoid Arthritis (ICD-10 ________) ☐ Other: ____________________ (ICD-10 ________)

Rituxan Dose: ☐ 1000mg **Dose Frequency:** ☐ Day 0, repeat dose in 2 weeks ☐ One time dose

Diagnosis: (GPS/MPA) ☐ Granulomatosis w/ Polyangiitis (ICD-10 __________) ☐ Microscopic Polyangiitis (ICD-10 __________)

Rituxan Dose: ☐ 375mg/m2 - **Dose Frequency:** ☐ weekly x 4 weeks ☐ Other: ____________________

☐ 500mg - **Dose Frequency:** ☐ Day 0, repeat dose in 2 weeks ☐ Other: ____________________

Diagnosis: (PV) ☐ Pemphigus Vulgaris (ICD-10 __________)

Rituxan Dose: ☐ Initial Dose: 1000mg IV ☐ Maintenance Dosing: 500mg IV

Dose Frequency: ☐ Day 0, repeat dose in 2 weeks ☐ Every 6 months

Diagnosis: (Other) ☐ Other: ____________________ (ICD-10 __________)

☐ Other: ____________________ (ICD-10 __________)

Rituxan 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: ____________________