



**AYSATHERAPEUTICS**

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:**  Rheumatoid Arthritis (ICD-10 \_\_\_\_\_ )  Other: \_\_\_\_\_ (ICD-10 \_\_\_\_\_ )  
(RA) **Rituxan 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) **Rituxan 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) **Rituxan 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 \_\_\_\_\_ )  
**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: \_\_\_\_\_

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