RITUXIMAB

(Including Rituxan and biosimilars: Riabni, Ruxience, Truxima)

FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List
• Hep B Panel: HBsAg, HBsAb (anti-HBs), HBcAb (anti-HBc)

PRIMARY DIAGNOSIS

☐ D59.10 Autoimmune hemolytic anemia, unspecified
☐ D89.1 Cryoglobulinemia
☐ I77.6 Arteritis, unspecified
☐ M05.10 Rheumatoid lung disease w/rheumatoid arthritis of unspecified site
☐ M05.79 Rheumatoid arthritis with rheumatoid factor multiple sites without organ system involvement
☐ M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified
☐ M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites
☐ M06.89 Other specified rheumatoid arthritis, multiple sites
☐ M06.9 Rheumatoid arthritis, unspecified
☐ M31.30 Wegener's granulomatosis without renal involvement
☐ M31.31 Wegener's granulomatosis with renal involvement
☐ M31.7 Microscopic polyangitis
☐ N01.7 Rapidly progressive nephrotic syndrome with diffuse crescentic glomerulonephritis
☐ N03.2 Chronic nephritic syndrome with diffuse membranous glomerulonephritis
☐ N04.2 Nephrotic syndrome with diffuse membranous glomerulonephritis
☐ Other:_____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: acetaminophen 650mg PO, diphenhydramine 25mg IV, and methylprednisolone 100mg IV 30 minutes prior to infusion
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Rituxan or biosimilar (Ruxience, Riabni, Truxima) may be used according to payer guidelines.
*To prohibit auto-substitution, please indicate specific brand required _____
☐ Rituximab 1000mg IV on Day 1 and Day 15, repeat course 24 weeks after initial dose
☐ Rituximab 375mg/m2 (_____mg) once weekly for 4 weeks
☐ Other:_____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals