PARAGON
INFUSION CENTERS

RITUXIMAB INFUSION ORDERS

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 INFUSION ORDERS

SELECT BRAND: ☐ **RITUXAN** ☐ **TRUXIMA** ☐ **RUXIENCE**

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

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 ________)

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 ________)

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 ________)

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 *Paragon Healthcare, 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: ____________ Date: ________

Physician Name: ____________

Phone: ________ Fax: ________ Contact Person: ________

INFUSION CENTER LOCATIONS

Phone: 877-365-5566
Fax: 855-889-2946

Texas
☐ Arlington ☐ Austin ☐ Dallas ☐ Houston ☐ North Hills
☐ Plano ☐ Round Rock ☐ San Antonio ☐ Stone Oak

Tennessee
☐ Knoxville

Georgia
☐ Atlanta

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