RITUXAN (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: J9310

Patient Weight: __________lbs. Allergies: ______________________________

☐ **Clinical/Progress Notes, Labs, Tests** supporting primary diagnosis attached

☐ **Strongly recommended Labs**: Quantitative Immunoglobulin (IgM,IgG and IgA): negative PPD or TB Gold; Anti-HCV antibody. Infusion will not be held if strongly recommended labs are not available.

☐ Require Labs: CBC, Hep B panel (HBsAg anti-HBc)

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

Lab Orders: ______________________________

RITUXAN ORDERS

Hepatitis B Protocol: Hep B surface antigen and Hep B Core AB total required.

**Date of last ☐ Remicade, ☐ Orencia, ☐ Humira, ☐ Enbrel dose ______________

Diagnosis: ☐ Rheumatoid Arthritis (ICD-10:__________)
☐ Other: ______________________________ (ICD-10:__________)

OPTION 1: Rituxan dose: ☐ 1000mg **Frequency:** ☐ 0, 15 days after initial treatment ☐ One time dose only

(OR)

Diagnosis: ☐ Granulomatosis with Polyangiitis (ICD-10:__________)
☐ Microscopic Polyangiitis (ICD-10:__________)

OPTION 2: Rituxan dose: ☐ 375mg/m2 **Frequency:** ☐ Weekly x 4 weeks ☐ Other: ________________

For severe vasculitis symptoms:

☐ Solu-Medrol 1000mg IV daily for _____days (1-3 days) within 14 days prior to Rituxan infusion.

☐ Solu-Medrol infuision to be followed by oral prednisone taper of 1mg/kg/daily (not to exceed 80mg daily)

☐ Prednisone Rx provided by prescribing provider

Protocol Pre-medication Orders: ☐ Tylenol 1000mg PO **and** Benadryl 50mg PO/IVP
☐ Solu-Medrol 100mg IVP ☐ Other: ______________________

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 LOCATION

☐ Arlington	☐ Austin	☐ Dallas	☐ Houston	☐ Knoxville	☐ North Hills	☐ Plano	☐ Round Rock	☐ San Antonio	☐ Stone Oak
P: 817.200.2530	P: 512.261.4800	P: 972.408.2777	P: 713.860.1755	P: 865-299-7525	P: 817.284.2700	P: 469-974-0565	P: 737-443-5230	P: 210.366.4358	P: 210.485.3700
F: 817.509.0011	F: 512.261.4803	F: 469.913.6894	F: 713.277.7219	F: 865-338-5604	F: 817.284.2701	F: 469-608-2072	F: 737-402-7698	F: 210.366.4896	F: 210.390.1738

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