

# MPP Infusion Centers

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Have a Question? Call: (855) 478-1528

A Multispecialty Physician Partner Company

## RITUXAN® (RITUXIMAB) ORDER FORM

REFERRAL STATUS			
<input type="checkbox"/> New Referral <input type="checkbox"/> Order Renewal <input type="checkbox"/> Restart <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> D/C Infusion (Medication(s) to D/C _____)			
LOCATION			
<input type="checkbox"/> Denver <input type="checkbox"/> Arlington <input type="checkbox"/> Dallas <input type="checkbox"/> Duncanville <input type="checkbox"/> Irving <input type="checkbox"/> Lewisville <input type="checkbox"/> Plano <input type="checkbox"/> Southlake <input type="checkbox"/> Tyler			
PATIENT INFORMATION			
PATIENT NAME:		DOB:	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ADDRESS:		PHONE #:	
WEIGHT: _____ LBS    _____ KG	HEIGHT:		EMAIL:
ALLERGIES:			
<b>Please check that the following are included</b>	<input type="checkbox"/> Patient demographics and insurance attached		<input type="checkbox"/> Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached
	<input type="checkbox"/> Current Medication List		
	<input type="checkbox"/> HepB Surf Ag (w/in 36 months)		<input type="checkbox"/> HepB Core (w/in 36 months)
PHYSICIAN INFORMATION			
Physician Name:		Email (if you would like referral updates):	
Practice Name:		Phone Number:	
Office Contact:		Fax Number:	
DIAGNOSIS			
<input type="checkbox"/> Granulomatosis w/ Polyangiitis (GPA) Wegner's	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Other:	
<input type="checkbox"/> Microscopic Polyangiitis (MPA)	<input type="checkbox"/> Pemphigus Vulgaris		
ICD-10 CODE:		Date of last infusion/injection:	
MEDICATION ORDERS			
<b>RITUXAN ORDERS:</b>			<b>Notes/Comments</b>
<input type="checkbox"/> Dose: 1000 mg IV on day 0, day 14, then repeat the course every _____ weeks Other Dosing: _____ mg /m <sup>2</sup> IV weekly for 4 weeks. Other Dosing: _____ mg IV every _____			
Physician Signature _____ Date (Order is Valid for One Year) _____ Infusion will be administered per MPP policy and protocol			
STANDING LAB ORDERS			
_____ Labs to be Drawn by Infusion Center		Frequency: _____ Every Infusion    _____ Other (please specify) _____	
_____ CMP    _____ CBC    _____ CRP    _____ ESRP    _____ HFR    _____ UA			
MPP RITUXAN ORDER FORM_01/2019			