



RITUXAN® (RITUXIMAB) ORDER FORM

(* - Required Fields)

___ **STAT REQUEST**

(*REASON MUST BE PROVIDED BELOW)

___ New Referral	___ Order Renewal	___ Medication/Order Change
___ Benefits Verification Only	___ Discontinuation Order	

Locations:

-----Colorado-----

___ Lakewood

-----Florida-----

- ___ Jacksonville
- ___ Kissimmee
- ___ Port St. Lucie
- ___ Winter Park

-----Texas-----

- ___ Arlington
- ___ Cedar Hill
- ___ Dallas
- ___ Denton
- ___ Ft. Worth Coming Soon
- ___ Irving
- ___ Rockwall
- ___ Southlake
- ___ Lewisville
- ___ Plano
- ___ Tyler

PATIENT INFORMATION			
NAME*:	DOB*:	SEX:	M F
ADDRESS:		PHONE:	
WEIGHT: LBS	KG	HEIGHT:	EMAIL:
ALLERGIES:			

PHYSICIAN INFORMATION			
PHYSICIAN NAME*:		PRACTICE NAME:	
ADDRESS:		OFFICE CONTACT*:	
PHONE:	FAX:	EMAIL (FOR UPDATES):	

RITUXAN ORDER*	ICD-10*
<i>(SELECT ONE OF THE FOLLOWING)</i>	_____
___ Dosing: 1000 mg IV on day 0, day 14, then repeat the course every ___ weeks	
OR	
___ Other Dosing: _____ mg /m ² IV weekly for 4 weeks	
OR	
___ Other Dosing: _____ mg IV every _____	
Physician Signature*	Date*(Order is Valid for One Year) <i>Infusion will be administered per MPP policy and protocols</i>

REQUIRED DIAGNOSIS:
___ Granulomatosis w/ Polyangiitis (GPA) Wegner's
___ Microscopic Polyangiitis (MPA)
___ Rheumatoid Arthritis
___ Pempigus Vulgaris
___ Other _____
*STAT REASON: <i>(STAT request will be assessed per MPP policy and protocol)</i>

REQUIRED DOCUMENTATION CHECKLIST:
___ Patient Demographics
___ Insurance Card/Information
___ Clinical/Progress Notes supporting DX
___ Current Medication List and H&P
___ HepB Surf Ag (w/in 12 months)
___ HepB Core Ab (w/in 12 months)
Last Infusion/Injection Date: _____

STANDING LAB ORDERS: ___ CMP ___ CBC
___ Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS: