immersiv HEALTH

RITUXIMAB ORDER FORM

RITUXAN® OR BIOSIMILAR (RUXIENCE®, RIABNI®, TRUXIMA®) MAY BE USED ACCORDING TO PAYOR GUIDELINES

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

***PLEASE COMPLETE ICD-10 FOR SPECIFIC DIAGNOSIS**

☐ M05. _____ Rheumatoid arthritis w/ rheumatoid factor

☐ M06. _____ Rheumatoid arthritis w/o rheumatoid factor

☐ ICD-10 CODE: _____ DESCRIPTION: _____

☐ M31.30 Granulomatosis w/ Polyangiitis (GPA/Wegener's)

☐ M31.7 Microscopic Polyangiitis (MPA)

REQUIRED DOCUMENTATION

☐ Insurance Information ☐ List of Medications ☐ Tried & Failed Therapies ☐ Most Recent History & Physical ☐ Full Hep B Panel

MEDICATION ORDER

Rituxan® or biosimilar (Ruxience®, Riabni®, Truxima®) may be used according to payor guidelines

To restrict substitution, indicate required brand here: _____

FOR RA

☐ Rituximab 1000mg IV in 500ml NS per protocol day 0 and day 14 every 4 months (16 weeks)

☐ Rituximab 1000mg IV in 500ml NS per protocol day 0 and day 14 every 6 months (24 weeks)

FOR GPA/MPA

☐ Rituximab 375mg/m^2 IV per protocol once weekly for 4 weeks

☐ **OTHER:** _____

PRE-MEDICATIONS

REQUIRED

☑ Acetaminophen: 500 mg	☑ PO	☐ IV
☑ Diphenhydramine: 25mg	☐ PO	☑ IV
☑ Methylprednisolone: 125mg	☐ PO	☑ IV

OTHER: _____ ☐ PO ☐ IV

LAB ORDERS

LAB: _____ FREQUENCY: _____

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 60 minutes following the first infusion. Administer per protocol.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ | _____ **DATE:** _____
(NO STAMPS)

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN