

**RITUXAN® Infusion Form  
For RA**

**Fax Referral To:  
877-438-9380**



**Birmingham, AL**  
F: 205-271-9971

**Huntsville, AL**  
F: 256-417-6408

**Knoxville, TN**  
F: 865-934-0249

**Nashville, TN**  
F: 615-645-4791

**Chantilly, VA**  
F: 703-935-2061

**PREVIOUS ADMINISTRATION**

**Please provide the following information:** Last Infusion Date: \_\_\_\_\_ Next Infusion Date: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Allergies: \_\_\_\_\_ Is the patient Diabetic: Y N ICD-10 Code: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Primary Diagnosis:** \_\_\_\_\_ Rheumatoid Arthritis  
\_\_\_\_\_ Other: \_\_\_\_\_

Please attach the following: 1. List of current Medications, Previous Drug Therapy History, including therapies trailed/failed and date of last administration: therapy: \_\_\_\_\_ Date: \_\_\_\_\_ Desired Washout Period: \_\_\_\_\_ weeks 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs including TB Screening Results and Hepatitis B Screening (including Hep B surface antigen & Hep B Core Antibody) 5. Infusion Center - Lab Orders (Check for Infusion Center to Manage): Obtain CBC with diff and platelets every \_\_\_\_\_

**Physician Information**

Prescribing Physician: \_\_\_\_\_ Practice Name: \_\_\_\_\_  
Practice Phone: \_\_\_\_\_ Practice Fax: \_\_\_\_\_  
Email: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
Co-managing Physician: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

**Medication Order**

**Medication: RITUXAN® (rituximab)**

**Administer Rituxan IV as per the below parameters: 1,000 mg Other: \_\_\_\_\_**

**Dosing Frequency:**

Infuse on Day 0 and Day 14 every 4 months

or

Infuse on Day 0 and Day 14 every 6 months

Other: \_\_\_\_\_

**Pre-Medication Orders:**

Acetaminophen 650 mg PO; diphenhydramine 50 mg PO; Methylprednisolone 100 mg IV

Administered 30 min prior to infusion and adjusted to the patient's needs

Other: \_\_\_\_\_

**Adverse Drug Reaction Protocol:** Manage any adverse reaction that may occur per approved ADR Protocol.

**By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

\_\_\_\_\_  
Physician's NPI#

\_\_\_\_\_  
Physician's Address

\_\_\_\_\_  
Prescriber's Signature

\_\_\_\_\_  
Date