RITUXAN® Infusion Form For RA

Fax Referral To: 877-438-9380

CONTINUUMRX Specialty Infusion Services

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	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. Presriber'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