Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Rituximab Unspecified Rheumatology Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:		
Patient Name:			Address:		
Date of Birth:			City, State, Zip:		
Height in inches:	Weight: LB or KG		Gender:	Allergies:	☐ See list ☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

- ☐ M05._____ - Rheumatoid arthritis with Rheumatoid factor
- ☐ M06._____ - Rheumatoid arthritis without Rheumatoid factor
- ☐ M05.79 - Rheumatoid arthritis with rheumatoid factor of multiple sites, without organ or systems invovement
- ☐ _____ - Other:

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Most recent labs including CBC with diff		NEXT INFUSION DATE:
4	Full medication list / Tried and failed therapies		**IF ORDER CHANGE:**
5	**REQUIRED:** Hepatitis B Panel for new start patients		☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive rituximabf receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, newly diagnosed cardiac arrhythmias, severe abdominal pain or vomiting, and/or surgery.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

*Per FDA labeling, Acetaminophen PO, Diphenhydramine IVP, and Methylprednisolone IVP is suggested prior to infusion

IV	Diphenhydramine	☐ 25mg	☐ 50mg					
	Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:				
	Famotidine	☐ 20mg	☐ 40 mg					
	Other:	☐						
PO	Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg	☐ 1000mg			
	Famotidine	☐ 20mg	☐ 40mg					
	Diphenhydramine	☐ 25mg	☐ 50mg					
	Fexofenadine	☐ 60mg	☐ 180mg					
	Cetirizine	☐ 10mg						
	Loratadine	☐ 10mg						
	Other:	☐						

SPECIFIC MEDICATION:

- ☐ Rituxan
- ☐ Ruxience
- ☐ Truxima
- ☐ Riabni

☐ **Any rituximab biosimilar may be used according to payer guidelines**

FREQUENCY:

- ☐ Infuse at 0 and 2 weeks every 4 months (16 weeks)
- ☐ Infuse at 0 and 2 weeks every 6 months (24 weeks)
- ☐ Other:_____

DOSE:

- ☐ 1000mg IV per 500ml NS to infuse per step protocol
- ☐ Other:_____

SPECIAL/LAB ORDERS:

- ☐ _____
- _____

☑ Refills x 12 months unless noted otherwise here:

Prescriber to monitor patient for symptoms of HBV infection and reactivation as clinically appropriate.

LINE USE/CARE ORDERS:

- ☑ Start PIV/Access CVC
- ☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	

Palmetto INFUSION

Checklist for referrals to Palmetto Infusion: Fax referral to 1.800.521.9640

- ☐ **Patient demographics - address, phone number, SS#, etc.**
- ☐ **Insurance information - copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com