

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> 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:
	<input type="checkbox"/> See list <input type="checkbox"/> 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 involvement
_____ - Other:

REQUESTED DOCUMENTATION:

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Most recent labs including CBC with diff	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Full medication list / Tried and failed therapies	FROM PREVIOUS	
5	REQUIRED: HBsAg, anti-HBc, and anti-HBs	THERAPY:	IF ORDER CHANGE:
			Continue current order until insurance approved

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive rituximab 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		PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					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:

<input type="checkbox"/>	_____
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Prescriber to monitor patient for symptoms of HBV infection and reactivation as clinically appropriate.

- Refills x 12 months unless noted otherwise here:

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	



Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- 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