



# Ruxience (rituximab-pvvr)

New Referral  Continue Treatment  Order Change

**Patient Information:**

Name: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 SS#: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Email: \_\_\_\_\_

**Physician Information:**

Referring Physician: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Fax #: \_\_\_\_\_

**Medication Orders**

Patient Weight: \_\_\_\_\_kg Patient Height: \_\_\_\_\_inches  First Dose  Maintenance Dose

Dosing:  1000mg IV on day 0, day 14, then repeat the course every \_\_\_\_ months  
 Other Dosing: 375mg/m2 IV every week for 4 weeks  
 \_\_\_\_\_mg IV on day 0, day 14, then repeat the course every \_\_\_\_ months

Premeds:  Benadryl 25mg IV  Tylenol 1000mg PO  Dexamethasone 20mg IV  \_\_\_\_\_

Indication / Diagnosis:  
 M05.79 Rheumatoid arthritis with rheumatoid factor without organ or systems involvement  
 M06.9 Rheumatoid arthritis, unspecified  
 M31.\_\_\_\_Granulomatosis with Polyangiitis  
 G36.0 Neuromyelitis Optica  
 Other (please specify) \_\_\_\_\_  
**ICD-10 (Required)** \_\_\_\_\_

**MD Signature:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Required Documentation**

Please send the following documents and records. This will help streamline the pre-authorization process.

- **If this is a continuation of a treatment, include the last infusion note**
- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- Current medication list

Most recent diagnostics results to include:

- CMP/BMP
- CBC with differential
- TB test: QGT, TSpot (within 2 years) - if HX of TB or + QGT, need negative Chest Xray report sent
- Hepatitis C-Ab
- Hepatitis B-Core Ab, B SAg, B SAb

*We will contact the patient and schedule their infusion appointment once we have the insurance pre-authorization completed.*

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