Truxima (rituximab-abbs)

☐ 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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