



Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Cha		PRESCRIBER INFORMATION	
Name: DOB:			
Address:		NDI II	
City, State, Zip:			
Phone: Alt. Phone:			
Email: SS#:		n	
Gender: M F Weight:(lbs) Ht:		Office Contact:	
Allergies:			
INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)			
Primary Insurance:			
Plan #:			
Group #:			
RX Card (PBM):			
BIN: PCN:			
CLINICAL INFORMATION			
rimary ICD-10 Code: Diagnosis Description:			
Secondary ICD-10 Code:	Diagnosis Description:		
Fertiary ICD-10 Code: Diagnosis Description:			
Hepatitis B Vaccination: ☐ Yes ☐ No Patient on Methotrexate: ☐ Yes ☐ No Line Access: ☐ PIV ☐ Port ☐ PICC ☐ Midline			
RITUXAN® ORDERS			
Prescription type: \square New start \square Res	tart Continued th	nerapy Total Doses Received: Da	ate of Last Dose:
Prescription type: ☐ New start ☐ Res	tart Continued th	Dose/Frequency	ate of Last Dose:
			Refills
Medication		Dose/Frequency	
Medication ☐ Rituximab (Rituxan) 100mg/10ml Vial	☐ 1000mg IV x 2 Dose	Dose/Frequency	Refills
Medication ☐ Rituximab (Rituxan) 100mg/10ml Vial ☐ Rituximab (Rituxan) 500mg/50ml Vial	☐ 1000mg IV x 2 Dose	Dose/Frequency es separated by 14 days, repeat every 24 weeks	Refills Refills:
Medication ☐ Rituximab (Rituxan) 100mg/10ml Vial ☐ Rituximab (Rituxan) 500mg/50ml Vial Pre-Medication	☐ 1000mg IV x 2 Dose ☐ Other:	Dose/Frequency es separated by 14 days, repeat every 24 weeks Directions	Refills Refills:
Medication Rituximab (Rituxan) 100mg/10ml Vial Rituximab (Rituxan) 500mg/50ml Vial Pre-Medication Acetaminophen Cetirizine	☐ 1000mg IV x 2 Dose ☐ Other: ☐ Dose/Strength 500mg 10mg ☐ 25mg IV/PO	es separated by 14 days, repeat every 24 weeks Directions Take 1-2 tablets PO prior to infusion or post-infus Take 1 tablet PO prior to infusion or as directed Take 1 tablet PO prior to infusion or as directed	Refills Refills: ion as directed
Medication Rituximab (Rituxan) 100mg/10ml Vial Rituximab (Rituxan) 500mg/50ml Vial Pre-Medication Acetaminophen	☐ 1000mg IV x 2 Dose ☐ Other: Dose/Strength 500mg 10mg	Dose/Frequency es separated by 14 days, repeat every 24 weeks Directions Take 1-2 tablets PO prior to infusion or post-infus Take 1 tablet PO prior to infusion or as directed	Refills Refills: ion as directed
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To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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