



LivWell
INFUSIONS

Rituxan and Biosimilars

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____
Patient Phone: _____

DOB: _____
SEX: M F

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis: M06.9 Rheumatoid arthritis, unspecified
M05.79 Rheumatoid arthritis with rheumatoid
factor without organ or systems involvement
Other _____
ICD-10 _____

Patients weight: _____
Lab Date: _____
Allergies: _____

ALSO INCLUDE...

Clinical/ Progress Notes
Demographics Sheet
Current Medications
Labs

RITUXAN ORDER

Choose a Medication: Rituxan Ruxience Truxima

Dose & Frequency : Initial/Reload Dosing: 1000 mg IV on day 0, day 14, then repeat the course every _____ weeks
Other Dosing _____ mg/m2 IV every weekly for 4 weeks

PreMeds: Benadryl 50mg IV APAP 500mg PO IV methylprednisolone 100mg IV methylprednisolone 1000mg

Date of last Infusion: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ Phone: _____

Practice Address: _____

Office Contact: _____ Fax: _____

NPI/ TIN: _____

Referring Physician's Signature _____

Date: _____