Rituxan and Biosimilars

LivWell INFUSIONS

Fax 888 511-7654 *Phone 888 864-7341*

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **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 ◯ 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:** _____