

# Rituximab Referral Form



INFUSION CENTER

www.biohealthic.com | info@biohealthic.com

## PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

## PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

## NURSING

Infusion to be administered per BioHealth protocols.

## LABORATORY ORDERS

CBC at each dose every \_\_\_\_\_

CMP at each dose every \_\_\_\_\_

CRP at each dose every \_\_\_\_\_

OTHER \_\_\_\_\_

## PREMEDICATIONS

acetaminophen (Tylenol) 500mg 650mg 1000mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl) 25mg 50mg PO IV

methylprednisolone (Solu-Medrol) 40mg 125mg IV

hydrocortisone (Solu-Cortef) 100mg IV

Other: \_\_\_\_\_

Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Frequency: \_\_\_\_\_

## REQUIRED DOCUMENTATION

- Patient Demographics
- Insurance Card /Information
- Progress Notes Supporting DX
- Current Medication List and H&P
- Hep B Surface Antigen (within 36 months)
- Hep B Core (if available)

## RITUXIMAB THERAPY ADMINISTRATION: Many payors require patients start therapy with a rituximab biosimilar. Choose ONE of these two options:

Infuse **Rituximab (Rituxan)** OR **Rituximab biosimilar** as required by patient's insurance.

Infuse this **Rituximab** product (subject to prior authorization):

\_\_\_\_\_  
(Products include: Rituxan, Ruxience, Truxima)

Dose: 1000 mg 375 mg/m2 500 mg

Other: \_\_\_\_\_

## Frequency:

One time dose

Day 0, repeat dose in 2 weeks, then repeat course every \_\_\_\_\_

weeks OR \_\_\_\_\_ months x \_\_\_\_\_ months

Day 0, repeat dose in 2 weeks

Weekly x 4 weeks

Every 6 months x \_\_\_\_\_ months

Other \_\_\_\_\_

*\*\*Order is valid for one year unless otherwise noted\*\**

Provider Name (Print) Provider Signature Date

Have a Question? (786)460-6044  
 Fax Referral Form To: (786)219-3917  
 8684 SUNSET DRIVE MIAMI FL 33143