

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.

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

LABORATORY ORDERS

CBC at each dose every _____

CMP at each dose every _____

CRP at each dose every _____

OTHER _____

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)

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: _____

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

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)

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