OKLAHOMA INFUSION SERVICES

Rituxan Order Form

Please fax form to: 405-726-9849

Patient Information

Patient Name:	DOB:	Phone:	Gender: M ☐ F ☐
Patient Address:	Email:	Insurance:	

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ C85.90 Non-Hodgkin Lymphoma, Unspecified, Unspecified Site
☐ C91.0 Acute Lymphoblastic Leukemia (ALL)
☐ C91.1 Chronic Lymphocytic Leukemia of B-Cell Type
☐ G70.00 Myasthenia Gravis (gMG) without Acute Exacerbation
☐ L10.0 Pemphigus Vulgaris
☐ M05.89 Other Rheumatoid Arthritis with Rheumatoid Factor of Multiple Sites
☐ M06.09 Rheumatoid Arthritis without Rheumatoid Factor, Multiple Sites
☐ M06.89 Other Specified Rheumatoid Arthritis, Multiple Sites
☐ M06.9 Rheumatoid Arthritis, Unspecified
☐ M31.30 Wegener's Granulomatosis without Renal Involvement
☐ M31.31 Wegener's Granulomatosis with Renal Involvement
☐ M31.7 Microscopic Polyangiitis
☐ Other: Code: __________ Description: ______________________________

Clinical Information:

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation
☐ Patient Weight: __________ lbs / __________ kg ☐ Patient Height: __________ in / __________ cm
☐ Allergies: ______________________________
☐ Therapies Tried and Failed: ______________________________
☐ TB Test: Date: __________ Results: ____________________ ☐ Hep B Test: Date: __________ Results: ____________________

Lab Orders

☐ CBC ☐ CMP ☐ ESR ☐ CRP ☐ HBsAg ☐ HBsAB ☐ HBcAB ☐ Quantiferon Gold
☐ Other: ______________________________

Lab Orders to be done by

☐ Oklahoma Infusion Services
☐ Referring Provider

Prescription Information

☐ Rituxan

☐ Dose and Frequency: 1000mg days 0 and 14; then repeat course every _____ weeks *(not sooner than every 16 weeks)*
☐ Dose and Frequency: 375mg/m^2 every week for _____ weeks
☐ Dose and Frequency: _____ mg/m^2 every ____________________ for ______________________________
☐ Dose and Frequency: _____ mg every ____________________ for ______________________________
☐ Dose and Frequency: Other: ______________________________

Pre-Medication Orders

☒ Solu-Cortef 50-100mg SIVP
☒ Tylenol tablet 500-1000mg PO PRN
☒ Benadryl 25mg PO PRN
☐ Other: ______________________________

Standing Orders for Adverse Reactions

☒ Stop infusion and initiate NS bolus
☒ Notify supervising physician and ordering provider
☒ Solu-Cortef 100mg SIVP signs of adverse reaction
☒ Benadryl 25mg SIVP for hives or bronchial inflammation
☒ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
☒ Oxygen 2-5L nasal cannula
☒ Albuterol 2.5mg inhaled PRN for chest tightness
☐ Other: ______________________________

Prescriber Information

Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:

______________________________ ______________________________

Prescriber's Signature: **Date:**

By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.