HEARTLAND INFUSION

Fax to Heartland (1.865.862.4556)
Questions? Call (1.865.862.4557)

Rituximab Order Form

Please fax completed form with patient demographics, front and back of insurance card(s), recent lab results, and recent office visit notes supporting diagnosis to 865.862.4556.

Type of Referral: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Location: ☐ Jackson ☐ Knoxville ☐ Morristown ☐ Kingsport

PATIENT INFORMATION

First Name: ______________________ Last Name: ________________ DOB: ________________ Gender: (**check one**) ☐ M ☐ F

Home Phone: _____________________ Mobile Phone: _________________

Email: ____________________________ Last 4 of SS#: __________________

Allergies: ____ Height: _________ Weight: _________

ICD-10 Diagnosis Code(s): ____________________________ Date of Diagnosis: _______________

TB Test (**circle one**): Skin Quantiferon Chest X-ray Result: _______________________ Date: _________

THERAPY ORDERS

☐ **Heartland to select product (based on clinical necessity, patient insurance, and product availability)** ☐ **Dispense as written**

☐ Truxima (rituximab-abbs) ☐ Rituxan (rituximab) ☐ Ruxience (rituximab-pvvr)

☐ Administer ______ mg on series Day 0 and series Day 14. Mix in ☐ 500ml ☐ 250ml. Repeat series every 24 weeks

☐ Administer ______ mg IV every _______ weeks

Infusion rate first infusion in series: 50mg/hr increasing every 30 min by 50mg/hr to maximum of 400mg/hr

Infusion rate subseqent infusion in series: 100mg/hr increasing every 30 min by 100mg/hr to a maximum of 400mg/hr **OR** (specify) ____

☐ Nursing per Heartland Nursing Procedures (include reaction management)

PRE-MEDICATION (per package insert)

☐ Solu-Medrol (methylprednisolone) IV ☐ 40 mg, ☐ 125 mg, ☐ other ________mg

☐ Tylenol (acetaminophen) 500mg PO

☐ Antihistamine (**choose one**)

☐ Benadryl (diphenhydramine) ______mg ☐ IV ☐ PO

☐ Other: ____

LABORATORY ORDERS

☐ CBC w/ DIFF ☐ each infusion ☐ Other: ______________________________

☐ CRP ☐ each infusion ☐ Other: ______________________________

☐ CMP ☐ each infusion ☐ Other: ______________________________

☐ ESR ☐ each infusion ☐ Other: ______________________________

☐ Hepatic Panel ☐ each infusion ☐ Other: ______________________________

☐ Renal Panel ☐ each infusion ☐ Other: ______________________________

☐ Quantiferon TB (annually) Due: ___________________

☐ Other: ____

PRESCRIBER'S INFORMATION

Prescriber Name: ____________________________________

License #: __________________ NPI: __________________ DEA: __________________

Address: ____

City: ______________________ State: _________ Zip: _________

Office Contact: _________________________

Office Phone: __________________________ Office Fax: _______________________

Prescriber's Signature: ______________________________