Infusion Specialist
c:
e:

Rituximab (Rituxan, Truxima, Ruxience)

Patient Referral Form

PATIENT INFORMATION

Date: Patient Name: DOB: Last 4 SSN:

Address: City: ST: Zip:

Primary Phone: Work Phone:

Gender: M F Weight lbs/kg: ICD-10 code: ICD-10 Description:

Patient Status: ❑ New to Therapy ❑ Continuing Therapy If yes, did patient have reaction with 1st dose? ❑ Y ❑ N

❑ Next Due Date (if applicable):_________________________

Primary Insurance: **Secondary Insurance:**

Member#: **Group#:** **Member#:** **Group#:**

ATTACH DOCUMENTS TO FAX

☑ Copy of insurance card(s) ☑ Labs ☑ Immunization results, include HBV and TB
☑ Patient demographics ☑ H&P (clinical) Other: ____

NURSING

☑ Provide nursing care per Axiva Standard Nursing Procedures, including reaction management & post-infusion observation
☑ Hepatitis B status and date (Please provide results):
____

PRE-MEDICATION ORDERS

❑ acetaminophen (Tylenol) ❑ 500mg / ❑ 650mg / ❑ 1000mg PO
❑ cetirizine (Zyrtec) 10mg PO
❑ loratadine (Claritin) 10mg PO
❑ diphenhydramine (Benadryl) ❑ 25mg / ❑ 50 mg ❑ PO / ❑ IV
❑ methylprednisolone (Solu-Medrol) ❑ 40mg / ❑ 125mg IV

❑ Other: ____
Dose: __________________ Route: __________________________
Frequency:

LABORATORY ORDERS

❑ CBC ❑ at each dose ❑ every _____________________
❑ CMP ❑ at each dose ❑ every _____________________
❑ CRP ❑ at each dose ❑ every _____________________
❑ Other: ____

THERAPY ADMINISTRATION

Please check preferred product:
❑ Rituximab (Rituxan)
❑ Rituximab-abbs (Truxima)
❑ Rituximab-pvvr (Ruxience)
☑ Mix in 0.9% sodium chloride or S5W to final concentration of 1-4mg/ml

- Dose: ❑ 1000mg / ❑ __________mg
- Mix in: ❑ 500ml / ❑ 250ml

FREQUENCY:
❑ on Series Day 0 and Series Day 14; repeat series every 24 weeks
❑ other: ____

- Infusion rate: First infusion in series: 50mg/hr, increasing every 30 minutes by 50mg/hr to maximum of 400mg/hr
- Subsequent infusion in series: 100mg/hr, increasing every 30 minutes by 100mg/hr to maximum of 400mg

☑ Flush with 0.9% sodium chloride at the completion of infusion
☑Monitor patient for 30 minutes post infusion

❑ Refills: ❑ Zero / ❑ for 12 months / ❑ Other:
(if not indicated order will expire one year from date signed)

PROVIDER INFORMATION

By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. Axiva Health Solutions, Inc., has my permission to contact the patient's health plan to obtain authorizations necessary to enable it to receive payment for services.

Physician Name: NPI: DEA: License:

Address: City: ST: Zip:

Phone: Fax: Office Contact:

________________________________ ____________ ♦ ________________________________ ____________
Physician Signature Required – Substitution Permitted Date Physician Signature Required – Dispense as Written Date

FAX completed form to Axiva 844.440.0101 **Patient Navigator 844.44-AXIVA (844.442.9482)**