RITUXIMAB Infusion

OptiMed
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Please complete each section of the referral form below and fax to OptiMed along with a copy (front and back) of all the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Information

Prescriber: ______________________ **NPI:** ______________________

Phone: ______________ **Fax:** ______________ **Office Contact:** ______________________

Address: ____

Patient Information

Name: ______________________ **DOB:** ______________________ ☐**M** ☐**F**

Address: ____

Phone: ______________ **2nd Phone:** ______________ **SSN:** ______________

Primary Language: ______________ **Functional Limitations:** ______________________

Clinical Information

Diagnosis (include ICD-10 code): ____

Weight: __________ ☐lb ☐kg **Height:** __________ ☐in **IV access:** ☐PIV ☐PICC ☐Port ☐Other: ______________

Allergies: ____ **Latex allergy?** ☐Yes ☐No

Prior treatments & reason for discontinuation: ____

Patient's first dose of RITUXIMAB? ☐Yes ☐No (If no, Treatment start date: __________ Date of last dose: __________)

Prior infusion reactions: ____

Hepatitis B screening: Date __________

HBsAg ☐Negative ☐Positive: ______________

Anti-HBc ☐Negative ☐Positive: ______________

Anti-HBs ☐Negative ☐Positive: ______________

History of kidney disease: ☐Yes ☐No If yes, SCr: ________ GFR/CrCl: ________ **History of heart failure:** ☐Yes ☐No

Prior immunosuppressant use: ☐Yes ☐No If yes, please list: ______________________

Prescription Information

Product Selection: *If no brand indicated, pharmacist to select RITUXIMAB brand based on clinical judgement, payer coverage, and cost to patient.*

Specific RITUXIMAB brand requested: ____

Nursing and Supplies: OptiMed to provide additional supply items and nursing care to prepare and administer product as per package instructions.

RITUXIMAB Dosing Regimen	Quantity
☐ Infuse RITUXIMAB 1000mg IV on day 1 and day 15 of a 24-week cycle.	☐ 2 doses (infusions) ☐ _____ doses (infusions)
☐ Other dose/frequency: ______________________	☐ _____ doses (infusions)

Premedication(s):
- ☐Methylprednisolone 125mg IVP 30 minutes prior to infusion
- ☐Acetaminophen 325-650mg PO 15-30 minutes prior to infusion
- ☐Diphenhydramine 25-50mg PO 15-30 minutes prior to infusion
- ☐Other premedication(s): ______________________

PRN Medication(s):
- ☐Acetaminophen 325-650mg PO Q4 hours PRN
- ☐Diphenhydramine 50mg IV x1 dose PRN
- ☐Methylprednisolone 125mg IV x1 dose PRN
- ☐Other PRN medication(s): ______________________

Lab orders: List any outpatient laboratory work related to this therapy you would like OptiMed to draw in conjunction with the patient's medication administration, including the frequency for each lab order. Lab orders are good for the life of the prescription order (one year) unless otherwise indicated. (Lab orders are subject to availability.)

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Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies in conjunction with the therapy prescribed above.

Signature: ______________________________ **Date:** ______________

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