



Rituxan Order Form

Select patient referral location: Blue Ash Worthington Crestview Hills Springfield West Cincinnati
Fax completed form to 888-977-0914. For new referrals, please include recent labs and last two office visit notes.

Toll Free Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable):	

2. PHYSICIAN INFORMATION

Physician's name:	NPI#:	
License #: <input type="text"/>	TIN#: <input type="text"/>	
DEA#: <input type="text"/>		
Address: <input type="text"/>		
City: <input type="text"/>	State: <input type="text"/>	Zip: <input type="text"/>
Office contact: <input type="text"/>	Email: <input type="text"/>	
Office phone: <input type="text"/>	Office fax: <input type="text"/>	

3. DIAGNOSIS INFORMATION (and year of diagnosis)

<input type="checkbox"/> Rheumatoid Arthritis (_____)	<input type="checkbox"/> Pemphigus Vulgaris (PV) (_____)
<input type="checkbox"/> Granulomatosis with Polyangitis (GPA) (_____)	<input type="checkbox"/> Microscopic Polyangitis (MPA) (_____)
<input type="checkbox"/> ICD 10 (_____)	<input type="checkbox"/> Other (specify): _____

4. INSURANCE INFORMATION *Please submit copies of the front and back or primary and secondary insurance cards with this referral.*

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

RITUXAN <input type="checkbox"/> Initial <input type="checkbox"/> Maintenance	PRE-MEDICATIONS <input type="checkbox"/> N/A
<input type="checkbox"/> Administer 1000mg at day 1 and day 15 Repeat every _____ weeks	<input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO
<input type="checkbox"/> First infusion in series: 50mg/hr, increasing every 30 minutes by 50mg/hr to maximum of 400mg/hr	<input type="checkbox"/> Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)
<input type="checkbox"/> Subsequent infusion in series: 100mg/hr, increasing every 30 minutes by 100mg/hr to maximum of 400mg/hr	<input type="checkbox"/> Diphenhydramine (Benadryl) <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> PO <input type="checkbox"/> IV (requires driver)
<input type="checkbox"/> Vital signs per HI protocol	<input type="checkbox"/> Methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg <input type="checkbox"/> 80mg <input type="checkbox"/> 125mg IV
<input type="checkbox"/> Anaphylaxis & hydration management per HI protocol	<input type="checkbox"/> Prednisone _____ mg PO
	<input type="checkbox"/> Other: _____
	POST-MEDICATIONS <input type="checkbox"/> N/A
	<input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO
	<input type="checkbox"/> Prednisone _____ mg PO
	<input type="checkbox"/> Other: _____

6. LABS

<input type="checkbox"/> CBC w/Diff	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> CRP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> CMP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> ESR	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Hepatic Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Renal Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Quantiferon TB Gold, annually, last completed (date): _____		
<input type="checkbox"/> Other (specify): _____		

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE