Site of Care
☐ Home Infusion
☐ Infusion Center
☐ Doctor's Office

Fax Referral to (855) 644-3687 or Email: Referrals@sandshealth.com

RITUXIMAB (AND BIOSIMILARS) ORDER FORM

☐ Rituximab (**Rituxan**) ☐ Rituximab-abbs (**Truxima**) ☐ Rituximab-pvvr (**Ruxience**) ☐ Rituximab-arrx (**Riabni**)

☐ Dispense As Written (DAW)
Will substitute for biosimilar based on insurance and availability

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Mobile Number: _____

Patient Weight: _____ Patient Height: _____ Allergies: _____

Other Medications: _____

DIAGNOSIS (Provider must specify)

☐ Rheumatoid Arthritis, ICD 10: _____ ☐ Microscopic Polyangiitis, ICD 10: _____

☐ Granulomatosis with Polyangiitis, ICD 10: _____ ☐ Pemphigus Vulgaris, ICD 10: _____

☐ Other: _____

Prior to treatment – ensure the following information is complete and attached with referral:

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Benadryl 25mg PO ☐ Methylprednisolone (Solu-Medrol) _____ mg IVP

☐ Other: _____ Dose: _____ Route: _____

☐ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Rituximab	☐ 500 mg ☐ 1,000 mg ☐ 375 mg/m²	IV	☐ Day 0 and 14 x1 course ☐ Day 0 and 14, Repeat in 6 months ☐ Day 0, 7, 14, and 21 x 1 course ☐ Other _____

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

LABS/SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

PROVIDER INFORMATION

Provider Name: _____ Provider NPI: _____ Contact: _____

Phone: _____ Fax: _____ Email Address: _____

Signature: _____ Date: _____

V1.0225