vitalcare of SOUTH DALLAS

RITUXIMAB INFUSION ORDERS

P: 945.212.3707 | **F:** 866.790.3580

☐ Home Infusion ☐ Alternate Site of Care

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 866.790.3580

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Patient Weight: _____ lbs. (required) Patient Height: _____ inches

Allergies: _____

Diagnosis: ☐ Rheumatoid Arthritis ☐ Granulomatosis w/ Polyangiitis ☐ Microscopic Polyangiitis
☐ Pemphigus Vulgaris ☐ Other: _____

ICD-10: _____

THERAPY ORDER

Rituximab: *(choose one)*

- ☐ Infuse rituximab **OR** rituximab biosimilar as required by patient's insurance
  - **Preferred product to be determine after benefits investigation (noted below)
- ☐ Do not substitute. Infuse the following rituximab product: _____

Dose: ☐ 1000mg ☐ 375mg/m2 ☐ 500mg ☐ Other: _____

Frequency: ☐ One time dose

☐ Day 0, repeat dose in 2 weeks, then repeat course every _____ weeks **OR** _____ months x _____ refill(s)

☐ Day 0, repeat dose in 2 weeks. One time order, do not repeat the course.

☐ Weekly x 4 weeks

☐ Every 6 months x _____ refill(s)

☐ Other: _____

Other orders: _____

Protocol Premedication orders: Solu-Medrol 100mg IV, Tylenol 1000mg PO, Benadryl 50mg PO/IV
☐ Other: _____

Substitute diphenhydramine with: ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Cetirizine 10mg IV

Lab orders: _____ **Frequency:** _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

*FOR VITAL CARE USE ONLY

Brand: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Vital Care of South Dallas* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Vital Care selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____

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vitalcare® of SOUTH DALLAS

COMPREHENSIVE SUPPORT FOR RITUXIMAB THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

- ☐ Has the patient had a documented contraindication/intolerance or failed trial of a glucocorticoids? ☐ Yes ☐ No
- ☐ Does the patient have an intolerance or failed trial to a rituximab biosimilar? ☐ Yes ☐ No If yes, which drug(s)? _____
- ☐ If appliable: Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, or conventional therapy (i.e., MTX, leflunomide)? ☐ Yes ☐ No If yes, which drug(s)? _____
- ☐ If applicable: Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Enbrel, Stelara, Cimzia)? ☐ Yes ☐ No If yes, which drug(s)? _____

☐ Supporting labs/diagnostics attached

☐ *If applicable* - Last known biological therapy: _____ and last date received: _____. If patient is switching to biologic therapies, please perform a wash-out period of _____ weeks prior to starting rituximab.

☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

☐ **CBC w/platelet**

☐ **Hepatitis B screening test completed. This includes Hepatitis B surface antigen and Hepatitis B core antibody total (not IgM) - attach results**
☐ **Positive** ☐ **Negative**

☐ Recommended labs, but not required: Quantitative immunoglobulins

If Hepatitis B results are positive - please provide documentation of medical clearance

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Vital Care will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (866) 790-3580 or call (945) 212-3707 for assistance

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