

# Rituxan Order Form

*Pre-filled order form for Rituxan (rituximab) — B-cell depleting therapy for autoimmune disease*

**REFERRING PROVIDER**

<b>PROVIDER NAME</b>	<b>NPI</b>	<b>DEA (IF CONTROLLED)</b>	<b>SPECIALTY</b>
----------------------	------------	----------------------------	------------------

---

<b>PRACTICE / CLINIC NAME</b>	<b>OFFICE PHONE</b>	<b>OFFICE FAX</b>
-------------------------------	---------------------	-------------------

---

<b>OFFICE CONTACT NAME</b>	<b>CONTACT PHONE</b>	<b>CONTACT EMAIL</b>
----------------------------	----------------------	----------------------

---

**PATIENT INFORMATION**

<b>PATIENT LAST NAME</b>	<b>FIRST NAME</b>	<b>MIDDLE INITIAL</b>
--------------------------	-------------------	-----------------------

---

<b>DATE OF BIRTH</b>	<b>SEX</b>	<b>PATIENT PHONE</b>	<b>BEST TIME TO CONTACT</b>
----------------------	------------	----------------------	-----------------------------

---

<b>ADDRESS</b>	<b>CITY, STATE, ZIP</b>
----------------	-------------------------

---

**INSURANCE**

<b>PRIMARY INSURANCE</b>	<b>MEMBER ID</b>	<b>GROUP #</b>
--------------------------	------------------	----------------

---

<b>SECONDARY INSURANCE (IF ANY)</b>	<b>MEMBER ID</b>	<b>GROUP #</b>
-------------------------------------	------------------	----------------

---

**DIAGNOSIS & CLINICAL JUSTIFICATION**

<b>PRIMARY DIAGNOSIS</b>	<b>ICD-10 CODE</b>
--------------------------	--------------------

---

<b>SECONDARY DIAGNOSIS (IF APPLICABLE)</b>	<b>ICD-10 CODE</b>
--	--------------------

---

**Common indications for this medication:** *Rheumatoid arthritis, Granulomatosis with polyangiitis (GPA), Microscopic polyangiitis (MPA), Pemphigus vulgaris*

**BRIEF CLINICAL SUMMARY / JUSTIFICATION FOR THERAPY**

---

**PRIOR THERAPIES TRIED AND OUTCOME**
**RITUXAN REFERENCE**

**Generic name:** rituximab  
**Specialty:** Rheumatology & Hematology  
**Typical infusion time:** 4&ndash;6 hours (first); 2&ndash;3 hours (subsequent)  
**Typical schedule:** Two infusions 2 weeks apart, repeated every 6 months  
**Biosimilars / brands:** Truxima, Ruxience, Riabni

**MEDICATION ORDER**

MEDICATION (DEFAULT: RITUXAN)	GENERIC / ALT (RITUXIMAB)	STRENGTH / FORMULATION
DOSE	FREQUENCY (TYPICAL: TWO INFUSIONS 2 WEEKS APART, REPEATED EVERY 6 MONTHS)	DURATION (TYPICAL: 4&NDASH;6 HOURS (FIRST); 2&NDASH;3 HOURS (SUBSEQUENT))
ROUTE	PRE-MEDICATIONS (IF ANY)	SPECIAL INSTRUCTIONS
ANTICIPATED START DATE	# OF DOSES AUTHORIZED	SUBSTITUTION ALLOWED (Y/N)
		BIOSIMILAR ACCEPTABLE (Y/N)

**REQUIRED LABS & MONITORING**

Check all labs the prescriber requires Arbor to verify before each infusion:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> CBC w/ differential           | <input type="checkbox"/> CMP                             | <input type="checkbox"/> Liver function panel   |
| <input type="checkbox"/> Hepatitis B/C panel           | <input type="checkbox"/> TB screen (T-SPOT or QFT)       | <input type="checkbox"/> Pregnancy test (urine) |
| <input type="checkbox"/> Iron studies (ferritin, TSAT) | <input type="checkbox"/> Vitamin levels (B12, D, folate) | <input type="checkbox"/> Other (specify below)  |

**OTHER LABS / MONITORING REQUIREMENTS**
**PRESCRIBER SIGNATURE**

By signing below I certify that this order is medically necessary, that I am the prescribing provider for this patient, and that I have reviewed the patient's clinical history relevant to this therapy. Arbor Infusion Therapy is authorized to coordinate scheduling, prior authorization, and benefits verification on the patient's behalf.

**PRESCRIBER SIGNATURE**
**PRINTED NAME**
**DATE**

---

*Form code: ARB-ORDER-RITUXAN · Submit to Arbor Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Arbor will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@arborinfuse.com*