Rituximab Referral Form

Preferred Clinic (select one):

PATIENT INFORMATION

Referral Status: New Referral Updated Referral Referral Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 Code (required): ICD-10 Description: Last Treatment Date: Last 4 Digits SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

☐ CBC at each dose every ____________________
☐ CMP at each dose every ____________________
☐ CRP at each dose every ____________________
OTHER ____

PREMEDICATIONS

acetaminophen (Tylenol) 500 mg 650 mg 1000 mg PO
cetirizine (Zyrtec) 10mg PO
loratadine (Claritin) 10mg PO
diphenhydramine (Benadryl) 25 mg 50 mg PO IV
methylprednisolone (Solu-Medrol) 40mg 125mg IV
hydrocortisone (Solu-Cortef) 100mg IV
Other: ____
Dose: ______________ Route: ____________________

REQUIRED DOCUMENTATION

Patient Demographics

Insurance Card /Information

Progress Notes Supporting DX

Current Medication List and H&P

Hep B Surface Antigen (within 36 months)

Hep B Core (if available)

RITUXIMAB THERAPY ADMINISTRATION: Many payors require patients start therapy with a rituximab biosimilar. Choose ONE of these two options:

Infuse **Rituximab (Rituxan)** OR **Rituximab biosimilar/generic** as required by patient's insurance.

Do not use biosimilar/generic (subject to prior authorization).

Dose: **1000 mg** **375 mg/m2** **500 mg**

Other: ________________________

____

Frequency:

One time dose

Day 0, repeat dose in 2 weeks, then repeat course every _____ weeks OR _____ months x ______ months

Day 0, repeat dose in 2 weeks

Weekly x 4 weeks

Every 6 months x ________ months

Other ____

Order is valid for one year unless otherwise noted

Provider Name (Print) **Provider Signature** **Date**

Email Referrals To: referrals@vivoinfusion.com OR Fax Below **Have a Question? Call (720) 902-4111**

Colorado: 303-418-4679	Michigan: 833-957-2188	New York: 800-540-1852	Texas: 469-340-0044
Connecticut: 203-724-4838	Minnesota: 763-290-0903	Ohio: 216-400-0674	Virginia: 804-500-5941
Florida: 904-930-4211	Nevada: 702-489-5744	Oklahoma: 918-770-4421	Wisconsin: 414-600-5383
Massachusetts: 781-202-1629	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244	