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:

Physician Preferred Method of Contact: ☐ Email: ☐ Fax: ☐ Phone:

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

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