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 (kg): Height:

ICD-10 Code (G35 must follow with new subcode): ICD-10 Description: Last Infusion 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:

STANDING ORDERS

☑ Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

☐ CBC w/ diff every _____

☐ CMP every _____

☐ CRP every _____

☐ OTHER _____

PREMEDICATIONS

☐ acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV

☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV

☐ Other: _____

Dose: _____ Route: _____

RITUXIMAB 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** _____

☑ **Clinic Specimen Collection Authorization: If required labs are not received prior to appointment, infusion clinic staff are authorized to draw required labs under the referring provider's NPI and route results back to the referring office.**

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)**

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

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
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

Referral is valid for one year unless otherwise noted.

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