PARAGON INFUSION CENTERS

RITUXIMAB ORDER FORM

P: 877.365.5566 | F: 855.889.2946

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

J Code: J9312

Patient Weight: _____ lbs. Allergies: _____

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached

☐ **Required Labs:** CBC w/ platelet, Hepatitis B antigen, Hepatitis B core total antibody

☐ **Recommended Labs:** Quantitative immunoglobulins (IgM, IgG, and IgA), Hepatitis C Virus, TB Test

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

RITUXIMAB ORDERS

SELECT BRAND: ☐ **RITUXAN** ☐ **TRUXIMA** ☐ **RUXIENCE**

Diagnosis: (RA)
☐ Rheumatoid Arthritis (ICD-10 _____)
☐ Other: _____ (ICD-10 _____)
Dose: ☐ 1000mg
Dose Frequency: ☐ Day 0, repeat dose in 2 weeks ☐ One time dose

Diagnosis: (GPS/MPA)
☐ Granulomatosis w/ Polyangiitis (ICD-10 _____) ☐ Microscopic Polyangiitis (ICD-10 _____)
Dose: ☐ 375mg/m2 - **Dose Frequency:** ☐ weekly x 4 weeks ☐ Other: _____
☐ 500mg - **Dose Frequency:** ☐ Day 0, repeat dose in 2 weeks ☐ Other: _____

Diagnosis: (PV)
☐ Pemphigus Vulgaris (ICD-10 _____)
Dose: ☐ Initial Dose: 1000mg IV ☐ Maintenance Dosing: 500mg IV
Dose Frequency: ☐ Day 0, repeat dose in 2 weeks ☐ Every 6 months

Diagnosis: (Other)
☐ Other: _____ (ICD-10 _____)
☐ Other: _____ (ICD-10 _____)
Dose: ☐ 1000mg ☐ 500mg ☐ 375mg/m2 ☐ Other: _____
Dose Frequency: ☐ One Dose ☐ Day 0, repeat dose in 2 weeks ☐ Other: _____

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

Order Frequency: ☐ One time order, no refills
☐ Repeat ordered dose every _____ week(s) **OR** _____ month(s) **X** _____ dose(s)

Additional Orders/Comments:

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____
Phone: _____ Fax: _____ Contact Person: _____

INFUSION CENTER LOCATIONS

☐ Alpharetta, GA ☐ Arlington, TX ☐ Atlanta, GA ☐ Austin, TX ☐ Bee Cave, TX ☐ Birmingham, AL ☐ Cape Coral, FL ☐ Clear Lake, TX ☐ Clearwater, FL ☐ Coppell, TX ☐ Creve Coeur, MO ☐ Dallas, TX ☐ Decatur, GA ☐ Denver, CO ☐ El Paso East, TX ☐ El Paso West, TX ☐ Fort Myers, FL ☐ Fort Worth, TX ☐ Hendersonville, TN ☐ Houston, TX ☐ Huntsville, AL ☐ Independence, MI ☐ Kansas City, MI ☐ Knoxville, TN ☐ Kyle, TX ☐ Lubbock, TX ☐ Montgomery, AL ☐ Murfreesboro, TN ☐ Naples, FL ☐ Nashville, TN ☐ North Hills, TX ☐ Plano, TX ☐ Round Rock, TX ☐ San Antonio, TX ☐ Sarasota, FL ☐ Smyrna, GA ☐ St. Louis, MI ☐ Stone Oak, TX ☐ Waco, TX ☐ West Houston, TX ☐ The Woodlands, TX ☐ Other: _____