



**PARAGON**  
HEALTHCARE

A Carelon Company

# RITUXIMAB INFUSION ORDERS

**P: 877-365-5566 | F: 855-889-2946**

## PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg

Allergies:

### Diagnosis Code ICD-10 (required):

### Diagnosis Description:

Patient Status:  New to Therapy  Continuing Therapy

Next Treatment Date:

## PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact:		Email:	
Address:		City:	State: ZIP:
NPI #:	DEA#:	Tax ID:	

## INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

## PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Frequency	Refills
<input type="checkbox"/> Infuse rituximab <b>OR</b> rituximab biosimilar IV *Preferred product TBD after benefits investigation (noted below)  <input type="checkbox"/> Do not substitute Infuse the following rituximab product IV: _____	<input type="checkbox"/> 1000mg <input type="checkbox"/> 375mg/m <sup>2</sup> <input type="checkbox"/> 500mg <input type="checkbox"/> _____	<input type="checkbox"/> Day 0, repeat dose in 2 weeks, then repeat course every ____ weeks <b>OR</b> ____ months  <input type="checkbox"/> Day 0, repeat dose in 2 weeks  <input type="checkbox"/> Weekly x 4 weeks  <input type="checkbox"/> Every 6 months  <input type="checkbox"/> Other: _____	<input type="checkbox"/> None <input type="checkbox"/> x 1 year <input type="checkbox"/> _____

**Protocol Pre-Medication Orders:** Acetaminophen 1000mg, Solu-Medrol 100mg IV, diphenhydramine 50mg PO/IV (if no contraindications)

Substitute diphenhydramine with:  Loratadine 10mg PO  Cetirizine 10mg PO  Cetirizine 10mg IV

Other orders: \_\_\_\_\_

Lab Orders: \_\_\_\_\_ Frequency: \_\_\_\_\_

Required labs to be drawn by:  Paragon  Referring Provider

## \*FOR PARAGON USE ONLY

Drug/Brand Selection: \_\_\_\_\_

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution.  Dispense as written

## PRESCRIBER SIGNATURE

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, and to select the preferred site of care for the patient.

Prescriber Signature: X

Date:

**PATIENT INFORMATION**

Name:

DOB:

**REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL**

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - Has the patient had a documented contraindication/intolerance or failed trial of a glucocorticoids?  Yes  No
  - Does the patient have an intolerance or failed trial to a rituximab biosimilar?  
 Yes  No If yes, which drug(s)? \_\_\_\_\_
  - If applicable: Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, or conventional therapy (i.e., MTX, leflunomide)?  Yes  No  
If yes, which drug(s)? \_\_\_\_\_
  - If applicable: Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Enbrel, Stelara, Cimzia)?  Yes  No  
If yes, which drug(s)? \_\_\_\_\_
- Supporting labs/diagnostics attached
- If applicable* - Last known biological therapy: \_\_\_\_\_ and last date received: \_\_\_\_\_. If patient is switching to biologic therapies, please perform a wash-out period of \_\_\_\_\_ weeks prior to starting rituximab.
- Other medical necessity: \_\_\_\_\_

**REQUIRED PRE-SCREENING**

- CBC w/platelet**
- Hepatitis B screening test completed. This includes Hepatitis B surface antigen and Hepatitis B core antibody total (not IgM) - attach results**
  - Positive**  **Negative**
- Recommended labs, but not required: Quantitative immunoglobulins

\*If Hepatitis B results are positive - please provide documentation of medical clearance\*