

**INFUSION & MEDICAL CENTER**

**1. Patient Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Patient Phone/Cell #** \_\_\_\_\_  
**Patient demographic and insurance information to be faxed with Infusion Order Form**

**2. Medical Information (Please select primary diagnosis and complete ICD10 Code):**  
 Primary Diagnosis: \_\_\_\_\_ Rheumatoid Arthritis ICD-10 Code: M0\_\_\_\_\_  
 \_\_\_\_\_ Other: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ (or attach list)

**3. Clinical Information – Please fax with Infusion Order Form:**

- Clinical MD Notes, labs, test supporting primary diagnosis
- Pre-Screening Documentation
  - Hepatitis B Screening Results (including Hep B surface antigen & Total Hep B Core Antibody)
- Previous Drug Therapy History, including therapies trailed and or failed and date of last infusion:
  - Previous biologic therapies: \_\_\_\_\_ Date: \_\_\_\_\_
  - Washout period of \_\_\_\_\_ weeks desired prior to the initiation of this ordered therapy
- Infusion Center – Lab Orders (Check for Infusion Center to Manage):
  - Obtain CBC with diff and platelets every \_\_\_\_\_

**Patient**  
**Weight:** \_\_\_\_\_ lbs.  
**Height:** \_\_\_\_\_ in.

**RITUXAN® (rituximab)** J Code: J9312

**4. Administer Rituxan IV as per the below parameters:**  
**Ordered Dose:**  1,000 mg  Other: \_\_\_\_\_  
**Dosing Frequency:**  
 Infuse on Day 0 and Day 14 every 4 months  
**or**  
 Infuse on Day 0 and Day 14 every 6 months  
 Other: \_\_\_\_\_

**Pre-Medication Orders:** Acetaminophen 650 mg PO; diphenhydramine 50 mg PO; Methylprednisolone 100 mg IV Administered 30 min prior to infusion and adjusted to the patient's needs

**Adverse Drug Reaction Protocol:** Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

**5. Physician Signature:** \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_  
Dispense as written Substitution permitted

Printed Physician's Name: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_

<p><b>FAX ALL INFORMATION</b>  <b>CENTRAL FAX 803.999.1754</b>  <b>ALTERNATE FAX 803.999.1887</b></p>	<p><b>INFUSION CENTER LOCATIONS</b>  <b>COLUMBIA CHARLESTON GREENVILLE</b>  <b>CENTRAL INTAKE PHONE 800.767.6337</b></p>
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