Horizon Infusions

**Rituxan®**
**Rituximab**

Select location:

- ☐ Akron
- ☐ Anderson
- ☐ Athens
- ☐ Canton
- ☐ Cincinnati (Blue Ash)
- ☐ Cincinnati (West Side)
- ☐ Cleveland (Mayfield)
- ☐ Cleveland (North Olmsted)
- ☐ Columbus (East Broad)
- ☐ Columbus (Hilliard)
- ☐ Columbus (Worthington)
- ☐ Dayton (Beavercreek)
- ☐ Dayton (Englewood)
- ☐ Findlay
- ☐ Liberty
- ☐ Mansfield
- ☐ Perrysburg
- ☐ Springfield
- ☐ Toledo
- ☐ Warren
- ☐ Crestview Hills (NKY)

**For new referrals, please include recent labs and last two office visit notes.**

**Fax completed form to 888-977-0914**

Phone: 877-787-8720 • www.horizoninfusions.com

## 1. PATIENT INFORMATION

| | |
|---|---|
| **Name:** | **DOB:** |
| **Phone:** | **Other Phone:** |
| **Email:** | |
| **Social Security #:** | **Allergies:** |
| **Gender:** ☐ M ☐ F | **Weight:** ☐ Lbs ☐ Kg |

**Patient Status:** ☐ New to therapy ☐ Continuing therapy ☐ Next due date *(if applicable)*:

## 2. INSURANCE INFORMATION (*required*)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

## 3. PHYSICIAN INFORMATION

| | | |
|---|---|---|
| **Physician Name:** | | **NPI#:** |
| **License #:** | **TIN#:** | **DEA#:** |
| **Address:** | | |
| **City:** | | **State** **Zip** |
| **Office Contact:** | | **Email:** |
| **Office phone:** | | **Office fax:** |

## 4. DIAGNOSIS INFORMATION (ICD 10 Code *Required*)

*Labs: Hep B required prior to initial infusion

- ☐ Rheumatoid Arthritis (_____)
- ☐ Granulomatosis with Polyangitis (GPA) (_____)
- ☐ Pemphigus Vulgaris (PV) (_____)
- ☐ Microscopic Polyangitis (MPA) (_____)
- ☐ Other: _____

## 5. PRESCRIPTION INFORMATION (*requires new order every 12 months*)

☐ RITUXAN ☐ RUXIENCE ☐ TRUXIMA ☐ RIABNI

☐ Initial ☐ Maintenance

☐ Administer 1000mg at Day 1 and Day 15; Repeat every _____ weeks

☐ First infusion in series: 50mg/hr, increasing every 30 minutes by 50mg/hr to maximum of 400mg/hr

☐ Subsequent infusion in series: 100mg/hr, increasing every 30 minutes by 100mg/hr to maximum of 400mg/hr

☐ Vital signs per HI protocol

☐ Anaphylaxis & Hydration Management per HI protocol

**PRE-MEDICATIONS** ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
- ☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
- ☐ Diphenhydrimine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)
- ☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV
- ☐ Prednisone _____ mg PO
- ☐ Other _____

**POST-MEDICATIONS** ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
- ☐ Prednisone _____ mg PO
- ☐ Other _____

## 6. LABS

| | | |
|---|---|---|
| ☐ CBC w/Diff | ☐ Each Infusion | ☐ Other Frequency (*specify*): _____ |
| ☐ CRP | ☐ Each Infusion | ☐ Other Frequency (*specify*): _____ |
| ☐ CMP | ☐ Each Infusion | ☐ Other Frequency (*specify*): _____ |
| ☐ ESR | ☐ Each Infusion | ☐ Other Frequency (*specify*): _____ |
| ☐ Hepatic Panel | ☐ Each Infusion | ☐ Other Frequency (*specify*): _____ |
| ☐ Renal Panel | ☐ Each Infusion | ☐ Other Frequency (*specify*): _____ |

☐ Quantiferon TB Gold, annually, last completed *(date)*: _____

☐ Other (*specify*): _____

## 7. SIGNATURE (required)

_____ _____

**PHYSICIAN'S SIGNATURE** **DATE**