LOWCOUNTRY
Rheumatology
A Member of Articularis Healthcare Group,Inc.

Please fax completed form, insurance card, and clinical documentation to:
FAX: (843) 793-6181

RITUXIMAB ORDER RA

☐ **New Start** ☐ **Maintenance: Last Dose Given**_____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	

Allergies ☐ NKDA ☐ Allergies: _____

Height: _____ Weight: _____

Indication:
☐ M05.___ RA with Rheumatoid Factor
☐ M06.___ RA w/o Rheumatoid Factor
☐ Other _____

DRUG: Rituxan | Truxima | Riabni | Ruxience	**DOSE**
☐ Rituximab-per insurance preferred	☐ 1000mg
☐ Rituxan	☐ Other _____
☐ Truxima (rituximab-abbs)	**FREQUENCY**
☐ Riabni (rituximab-arrx)	☐ At days 0 and 15(approximately)
☐ Ruxience (rituximab-pvvr)	☐ At days 0 and 15(approximately) every_____months
	☐ Other_____

PREMEDICATION ORDERS: *antihistamine, acetaminophen and 100mg methylprednisolone are recommended in the PI*

☐ Acetaminophen po: ☐ 1000mg ☐500mg 30 min prior to infusion.
☐ Diphenhydramine: ☐ 25mg PO ☐ 50mg PO ☐ 25mg IVP 30 min prior to infusion.
☐ Solu-Medrol: ☐ 62.5mg IVP ☐ 100mg IVP ☐ Other_____ 30 min prior to infusion.
☐ Other _____

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:
☐ Face Sheet / Patient Demographics
☐ Insurance card(s) – copy of front & back
☐ Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
Most Recent Labs (within last 4-8 weeks) – Required:
☐ CBC ☐ CMP ☐ Lipids ☐ TB ☐ Hep B Other: _____