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 NEPHROLOGY

☐ **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:
☐ I77.8___ ANCA positive vasculitis
☐ N04.___Nephrotic Syndrome
☐ N05.___ Focal Segmental glomerulonephritis
☐ Other _____

DRUG: Rituxan | Truxima | Riabni | Ruxience
☐ Rituximab-per insurance preferred
☐ Rituxan
☐ Truxima (rituximab-abbs)
☐ Riabni (rituximab-arrx)
☐ Ruxience (rituximab-pvvr)

INDUCTION DOSES:	**MAINTENANCE DOSES:**
☐ 375mg/m2 every week X 4 weeks	☐ 500mg IV at day 0 and 15 (approximately)
☐ 1000mg IV at day 0 and 15 (approximately)	☐ 500mg IV every _____
☐ Other _____	☐ 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 <u>ALL</u> 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: _____