Rituximab Biosimilars

Provider Order Form Rev. 8/2024

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Rheumatoid Arthritis (M05.70-M05.9, M06.00-M06.09, M06.9), ICD10 _____

☐ Pemphigus Vulgaris (L10.0-L14), ICD10 _____

☐ Other: _____, ICD10 _____

Granulomatosis with Polyangiitis (GPA):

☐ Wegener's granulomatosis without renal involvement, M31.30

☐ Wegener's granulomatosis with renal involvement, M31.31

☐ Microscopic polyangiitis, M31.7

INFUSION ORDERS

MEDICATION

Rituximab biosimilars available:

☐ Riabni® (rituximab-arrx)

☐ Ruxience® (rituximab-pvvr)

☐ Rituxan® (rituximab)

☐ Truxima® (rituximab-abbs)

DOSE, DIRECTIONS, and DURATION

For Rheumatoid Arthritis

☐ Infuse 1000 mg IV over _____ hours on Days 1 and 15 every _____ weeks x 1 year

For GPA

☐ **INDUCTION:** Infuse _____ mg (375 mg/m^2) IV over _____ hours once weekly x 4 doses

☐ **MAINTENANCE:** Infuse 500 mg IV over _____ hours on Days 1 and 15 every 6 months x 1 year

For Pemphigus Vulgaris

☐ **INITIAL:** Infuse 1000 mg IV over _____ hours on Days 1 and 15

☐ **MAINTENANCE:** Infuse 500 mg IV over _____ hours every 6 months x 1 year

☐ **OTHER:** _____

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP

☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____

☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ NPI: _____ TIN: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

LAB AND TEST RESULTS (required)

- Provide copy of TB screening (within 12 months) and must be completed annually by: ☐ Infusion Center ☐ Referring Physician
- Provide copy of Hepatitis B Screening
- Provide copy of baseline CBC, CMP and LFT

Diagnostic Test Results ***Please attach copy for all items checked.***

For Granulomatosis with Polyangiitis:

☐ Anti-neutrophil cytoplasmic antibody test (ANCAs)

PRIOR FAILED THERAPIES

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____