

### RITUXIMAB ORDER FORM

#### REFERRAL TYPE

New Referral     
  Order Renewal     
  Restart     
  Frequency Change     
  Dosage Change

#### PREFERRED LOCATION

<input type="checkbox"/> 2730 University Blvd. West   Suite 714 Wheaton, MD 20902	<input type="checkbox"/> 14995 Shady Grove Road   Suite 250 Rockville, MD 20850	<input type="checkbox"/> 5454 Wisconsin Avenue   Suite 600 Chevy Chase, MD 20815
<input type="checkbox"/> 18111 Prince Philip Drive   Suite 323 Olney, MD 20832	<input type="checkbox"/> 71 Thomas Johnson Drive Frederick, MD 21702	<input type="checkbox"/> 2021 K Street, NW   Suite 300 Washington, DC 20006
	<input type="checkbox"/> 8270 Willow Oaks Corporate Drive   Suite 150 Fairfax, VA 22031	

#### PATIENT INFORMATION

Name:	DOB:	Email:
Address:	Weight:                      KG                      LBS	Phone:

#### REFERRING PHYSICIAN INFORMATION

Name:	NPI:	
Office Contact Name:	Phone:	Fax:
Address:		

#### RITUXAN ORDER

**OFF-LABEL diagnosis, dose and frequency are subject to medical review and approval.**

Preferred Product:  None     Rituxan     Truxima

#### Diagnosis:

- M05.79—Rheumatoid arthritis with rheumatoid factor of multiple sites w/o organ or systems involvement
- M05.89—Other rheumatoid arthritis with rheumatoid factor of multiple sites
- M06.09—Rheumatoid arthritis w/o rheumatoid factor, multiple sites
- M06.89—Other specified rheumatoid arthritis, multiple sites

#### Dosing/Frequency:

1000mg IV on day 0, day 14, then repeat the course every \_\_\_\_\_ weeks

#### Diagnosis:

- M31.30—Wegener's granulomatosis w/o renal involvement
- M31.31—Wegener's granulomatosis with renal involvement

#### Dosing/Frequency:

375mg/m<sup>2</sup> IV qwk for 4weeks     
  1000mg Day1 & Day15 every 6months     
  500mg q6months

Other Diagnosis: \_\_\_\_\_ ICD-10 Code (Required): \_\_\_\_\_

Special Instructions:

Physicians Signature: \_\_\_\_\_ Date: \_\_\_\_\_ (Order is Valid for One Year)

#### REQUIRED DOCUMENTATION

##### Please fax the following documents and records:

- Patient Demographics
- Two most recent office notes (Supporting the DX and treatment ordered)
- Most recent labs that include values for:
  - CMP, CBC, HBV Surface Antigen
  - TB Screening (PPD, QFT Gold or Tspot) or recent chest x-ray
- Copy of the patient's insurance card(s) – front and back
- Medication History
- For continuation of treatment, include the last infusion note

***We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.***