arise infusion THERAPY SERVICES

A DIVISION OF ARTHRITIS AND RHEUMATISM ASSOCIATES, PC

Fax To: 301-424-3590
Have a Question? Call: 240-514-5000

RITUXIMAB ORDER FORM

REFERRAL TYPE

☐ New Referral ☐ Order Renewal ☐ Restart ☐ Frequency Change ☐ Dosage Change

PREFERRED LOCATION

☐ 2730 University Blvd. West | Suite 714 Wheaton, MD 20902	☐ 14995 Shady Grove Road | Suite 250 Rockville, MD 20850	☐ 5454 Wisconsin Avenue | Suite 600 Chevy Chase, MD 20815
☐ 18111 Prince Philip Drive | Suite 323 Olney, MD 20832	☐ 161 Thomas Johnson Drive | Suite 250 Frederick, MD 21702	☐ 2021 K Street, NW | Suite 300 Washington, DC 20006
	☐ 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/m² 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.