# RITUXAN (RITUXIMAB) Referral Order Form

**FAX (877) 637-6691**

VASCO INFUSION

WWW.VASCOINFUSION.COM

PH: 602-346-0204 FAX: 877-637-6691

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions *indicate name of drug(s) _____

*Vasco Infusion can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.*

## PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

## PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

## RITUXAN MEDICATION ORDERS

Patient Weight:_____ kg ☐ Initial/Reload Dosing: _____1000 mg IV on day 0, day 14, then repeat the course every weeks.

Refills: _____ ☐ Other Dosing:_____ mg/m$^2$ IV every weekly for 4 weeks

Premeds: ☐ diphenhydramine ☐ APAP ☐ IV methylprednisolone 100mg ☐ IV methylprednisolone 1000mg

### INDICATION/DIAGNOSIS

☐ Rheumatoid Arthritis
☐ Granulomatosis w/ Polyangiitis (Wegner's) (GPA)
☐ Microscopic Polyangiitis (MPA)
☐ Other *(please specify in notes)*

***ICD-10** _____ **required**

### NOTES (ADDITIONAL INFO)

_____ _____

Referring Physician's Signature Date

## REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

## ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ HepB Surf Ag (w/in 12 months) ☐ HepB Core Ab (w/in 12 months)

☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

**APPOINTMENT DATE & TIME:** _____

***FOR OFFICE USE ONLY***