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: _____

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.

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

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

INDICATION/DIAGNOSIS

☐ M05.79 Rheumatoid arthritis with rheumatoid factor without organ or systems involvement
☐ M06.9 Rheumatoid arthritis, unspecified
☐ G36.0 Neuromyelitis Optica
☐ Other *(please specify in notes)*

***ICD-10 required**

_____ _____

Referring Physician's Signature Date

NOTES (ADDITIONAL INFO)

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