# RITUXAN (RITUXIMAB) Referral Order Form

FAX (855) 891-2191

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# MPP Infusion Centers

www.mppinfusion.com

Referral Phone: (855) 478-1528 Referral Fax: (855) 891-2191 Email: mppreferral@mppinfusion.com

☐ Denver ☐ Arlington ☐ Dallas ☐ Duncanville ☐ Irving ☐ Lewisville ☐ Plano ☐ Southlake

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

## PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

## PHYSICIAN INFORMATION

Referring Physician: _____

Practice Name: _____

Specialty: _____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

Contact Email: _____

## 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

### INDICATION/DIAGNOSIS

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

***ICD-10 _____ required**

### NOTES (ADDITIONAL INFO)

_____ _____

Referring Physician's Signature Date *valid for one year

### STANDING LAB ORDERS

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

**Orders:**
☐ CMP ☐ CBC ☐ CRP
☐ ESRP ☐ HFP ☐ UA

**Frequency:**
☐ Every Infusion
☐ Other _____

## 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 36 months) ☐ HepB Core Ab (w/in 36 months)

**APPOINTMENT DATE & TIME:** _____

***FOR OFFICE USE ONLY***