

Rituxan Enrollment Form

TwelveStone Health Partners

Date: _____
 Patient Name: _____
 Date of Birth: _____

Fax Referral To:
(800) 223-4063
 Direct Phone: (615) 278-3350
 Toll Free: (844) 893-0012



PREVIOUS ADMINISTRATION

If YES, please provide the following information:	If NO, please indicate desired location for first dose:
Last Infusion Date: _____	<input type="checkbox"/> Physician's Office
Next Infusion Date: _____	TwelveStone Infusion Center:
	<input type="checkbox"/> Canton <input type="checkbox"/> Chattanooga <input type="checkbox"/> Knoxville <input type="checkbox"/> Mount Juliet <input type="checkbox"/> Murfreesboro
	<input type="checkbox"/> Other: _____
	Desired Start Date: _____

DIAGNOSIS

Description	ICD-10 Code
<input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Granulomatosis c Polyangiitis <input type="checkbox"/> Microscopic Polyangiitis	<input type="checkbox"/> M06.9 <input type="checkbox"/> M31.30 <input type="checkbox"/> M31.7

OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

<input type="checkbox"/> This signed order form	<input type="checkbox"/> History and Physical
<input type="checkbox"/> Patient Demographics and Insurance Information	<input type="checkbox"/> Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)

Patient Weight: _____ Kg Height: _____ Inches/CM BSA: _____ Allergies: _____

Line Access: PIV PICC (SL DL TL) PORT (Huber size _____ Gauge _____ Length) Other IV Access: _____

MEDICATION	DIRECTIONS	REFILLS	BASELINE LABWORK REQ'D TO INITIATE (Check for TwelveStone to draw)
<input type="checkbox"/> Rituxan	<input type="checkbox"/> RA - Infuse 1000mg IV for 2 doses separated by 2 weeks. Repeat 2 dose course every _____ weeks. Initiate rate at 50mg/hr and increase every 30 min to a max 400mg/hr. <input type="checkbox"/> GPA & MPA - Infuse _____ mg (375mg/m2) weekly for 4 weeks. Initiate rate at 50mg/hr and increase every 30 min to a max 400mg/hr.		<input type="checkbox"/> CBC w/Differential <input type="checkbox"/> Anti-JCV Antibodies <input type="checkbox"/> Hepatitis Panel

LAB ORDERS - To be drawn by TwelveStone

<u>Order</u>	<u>Frequency</u>
CBC w/Differential	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
CBC w/o Differential	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
CMP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
BMP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
CRP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Sed Rate	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Calcium	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Tb QuantiFERON Gold	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Hepatitis Panel	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Other _____	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____

PRE-MEDICATIONS - *RECOMMENDED

<u>Oral</u>	<u>IV</u>
*Acetaminophen: <input type="checkbox"/> 325mg <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg	Dexamethasone: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg
Cetirizine: <input type="checkbox"/> 10mg	Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg
*Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg
Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg	*Methylprednisolone: <input type="checkbox"/> _____mg IV over _____ mins
Ibuprofen: <input type="checkbox"/> 200mg	Ondansetron: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg
Loratadine: <input type="checkbox"/> 10mg	Meperidine: <input type="checkbox"/> 25-50mg IV PRN (C2 - must be ordered via eScript or hard copy)
Ondansetron: <input type="checkbox"/> 4mg	

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Physician's Phone # _____	Physician's NPI# _____	Physician's Fax # _____	Physician's Address _____
Dispense as Written _____	Date _____	Substitution Allowed _____	Date _____

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