Rituximab Enrollment Form

Date: _____

Patient Name: _____

Date of Birth: _____

TwelveStone Health Partners

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:P
Last Infusion Date:_____ Next Infusion Date:_____	☐ **Physician's office** **TwelveStone Infusion Center** ☐ Canton ☐ Chattanooga ☐ Knoxville ☐ Mount Juliet ☐ Murfreesboro ☐ Other:_____ Date of last dose:_____

DIAGNOSIS

☐ Rheumatoid Arthritis ☐ Granulomatosis c Polyangiitis ☐ Microscopic Polyangiitis	☐ M06.9 ☐ M31.7 ☐ M31.30

OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

☐ This signed order form ☐ History and Physical

☐ Patient Demographics and Insurance Information ☐ Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

MEDICATION	DIRECTIONS	REFILLS	BASELINE LABWORK REQ'D TO INITIATE (Check for TwelveStone to draw)
☐ Rituximab_____ (Please specify Rituxan, Ruxience, or Truxima if desired)	☐ RA - Infuse 1000mg IV for 2 doses separated by 2 weeks. Repeat 2 dose course every ____ weeks. Infuse per protocol --- ☐ GPA & MPA - Infuse ____ mg (375mg/m2) weekly for 4 weeks. Infuse per protocol		☐ CBC w/Differential ☐ Anti-JCV Antibodies ☐ Hepatitis Panel

LAB ORDERS - To be drawn by TwelveStone

Order			Frequency	
CBC w/ Differential	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____
CBC w/o Differential	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____
CMP	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____
BMP	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____
CRP	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____
Sed Rate	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____
Calcium	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____
Tb QuantiFERON Gold	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____
Hepatitis Panel	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____
Other:	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: _____

Pre-medications - *Check here for NO pre-meds _____

Oral

*Acetaminophen: [ ] 325mg [ ]500mg [ ] 650mg
Cetirizine: [ ] 10mg
*Diphenhydramine: [ ] 25mg [ ] 50mg
Famotidine: [ ] 20mg [ ] 40mg
Ibuprofen: [ ] 200mg
Loratidine: [ ] 10mg
Ondansetron: [ ] 4mg

IV

Dexamethasone: [ ] 4mg [ ] 8mg
Diphenhydramine: [ ] 25mg [ ] 50mg
Famotidine: [ ] 20mg [ ] 40mg
*Methylprednisolone: [ ] _____ mg IV over _____ mins
Ondansetron: [ ] 4mg [ ] 8mg
Meperidine: ☐ 25-50mg IV PRN (C2 - must be ordered via eScript or hard copy)

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: _____ Printed Name: _____ Substitution Allowed: _____ Date: _____

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