

Rituximab 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:P
Last Infusion Date: _____	<input type="checkbox"/> Physician's office 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: _____ Date of last dose: _____
Next Infusion Date: _____	

DIAGNOSIS

<input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Granulomatosis c Polyangiitis <input type="checkbox"/> Microscopic Polyangiitis	<input type="checkbox"/> M06.9 <input type="checkbox"/> M31.7 <input type="checkbox"/> 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)
<input type="checkbox"/> Rituximab _____ (Please specify Rituxan, Ruxience, or Truxima if desired)	<input type="checkbox"/> RA - Infuse 1000mg IV for 2 doses separated by 2 weeks. Repeat 2 dose course every ____ weeks. Infuse per protocol <hr/> <input type="checkbox"/> GPA & MPA - Infuse ____ mg (375mg/m2) weekly for 4 weeks. Infuse per protocol		<input type="checkbox"/> CBC w/Differential <input type="checkbox"/> Anti-JCV Antibodies <input type="checkbox"/> Hepatitis Panel

LAB ORDERS - To be drawn by TwelveStone

Order	Frequency
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 - *Check here for NO pre-meds _____

<p style="text-align: center;">Oral</p> *Acetaminophen: [] 325mg [] 500mg [] 650mg Cetirizine: [] 10mg *Diphenhydramine: [] 25mg [] 50mg Famotidine: [] 20mg [] 40mg Ibuprofen: [] 200mg Loratidine: [] 10mg Ondansetron: [] 4mg	<p style="text-align: center;">IV</p> Dexamethasone: [] 4mg [] 8mg Diphenhydramine: [] 25mg [] 50mg Famotidine: [] 20mg [] 40mg *Methylprednisolone: [] _____ mg IV over _____ mins Ondansetron: [] 4mg [] 8mg Meperidine: <input type="checkbox"/> 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: _____

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by calling 615-895-0186 or faxing back to the originator.