BluHaven HEALTH

Rituximab Referral Form

Fax: (984) 370-2352
Phone: (984) 370-2350
Email: connect@bluhaven.com

Patient Information

Name: _____ DOB: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Weight: _____ ☐ lbs ☐ kgs

Allergies: ☐ NKDA ☐ _____

Required Documentation Insurance Card | History & Physical | Patient Demographics | Most Recent Labs | Medication List | Hep B Panel: HBsAg, HBsAb (anti-HBs), HBcAb (anti-HBc)

Primary Diagnosis

- ☐ D59.10 Autoimmune hemolytic anemia, unspecified
- ☐ D89.1 Cryoglobulinemia
- ☐ I77.6 Arteritis, unspecified
- ☐ M05.10 Rheumatoid lung disease w/rheumatoid arthritis of unspecified site
- ☐ M05.79 Rheumatoid arthritis with rheumatoid factor multiple sites without organ system involvement
- ☐ M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified
- ☐ M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites
- ☐ M06.89 Other specified rheumatoid arthritis, multiple sites
- ☐ M06.9 Rheumatoid arthritis, unspecified
- ☐ M31.30 Wegener's granulomatosis without renal involvement
- ☐ M31.31 Wegener's granulomatosis with renal involvement
- ☐ M31.7 Microscopic polyangitis
- ☐ N01.7 Rapidly progressive nephrotic syndrome with diffuse crescentic glomerulonephritis
- ☐ N03.2 Chronic nephritic syndrome with diffuse membranous glomerulonephritis
- ☐ N04.2 Nephrotic syndrome with diffuse membranous glomerulonephritis
- ☐ M31.7 Microscopic polyangitis
- ☐ Other: _____

Order Information

Lab Orders (Include frequency)

Please list any labs to be drawn by the infusion clinic: _____

Pre-Medications

☑ Per infusion clinic protocol: acetaminophen 650mg PO, diphenhydramine 25mg IV, and methylprednisolone 40mg PO 30 minutes prior to infusion

☐ Provider Prescribed: _____

Primary Medication Order

Rituxan or biosimilar (Ruxience, Riabni, Truxima) may be used according to payer guidelines.

**To prohibit auto-substitution, please indicate specific brand required* _____

☐ Rituximab 1000mg IV on Day 1 and Day 15, repeat course 24 weeks after initial dose

☐ Rituximab 375mg/m2 (_____mg) once weekly for 4 weeks

☐ Other: _____

First Dose: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted: _____

Line Use/Care Orders

☑ Start PIV/ACCESS CVC ☑ Flush device per BluHaven Health's protocol (see BluHaven.com for policy)

☐ Other Flush Orders: Please fax other line care orders if checking this box.

Adverse Reaction & Anaphylaxis Orders

☑ Administer acute infusion reaction and anaphylaxis medications per BluHaven Healths' protocol (see BluHaven.com for policy)

☐ Other: Please fax other reaction orders if checking this box.

Provider Information

Name: _____ Office Contact: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____ NPI: _____

I authorize BluHaven Health and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this order and any future related orders for the patient listed above.

_____ _____

Provider Signature *Date*