SPRINGSIDE INFUSION

# Rituxan and biosimilars

## Patient information

**Patient name** _____ **DOB** _____

**Mobile number** _____ **Weight** _____ ☐ kgs ☐ lbs

**Diagnosis**

☐ Rheumatoid arthritis
☐ Granulomatosis with polyangiitis
☐ Microscopic polyangiitis (m31.7)
☐ Pemphigus vulgaris (l10.0)
☐ Other _____

**Allergies** ☐ NKDA ☐ _____

## Medication instructions

**Pre-medications**

☐ N/A
☐ Provider prescribed: _____

**Medication order**

Dose
☐ 500 mg
☐ 1,000 mg
☐ 375 mg/m2
☐ Other _____

Frequency
☐ Day 0 and 14 x 1 course
☐ Day 0 and 14, repeat in 6 months
☐ Day 0, 7, 14, and 21 x 1 course
☐ Other _____

**Medication route**

☐ IV
☐ Other _____

**Lab order** (Include frequency)

Please list any labs to be drawn by the infusion clinic:
☐ N/A
☐ _____

**Prerequisites**

Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics

**Please send to** ☐ Columbia, MD ☐ Silver Spring, MD ☐ Bowie, MD ☐ Frederick, MD

## Referring provider information

**Referring provider name** _____ **NPI** _____

**Practice name** _____

**Point of contact** Name _____ Email _____ Phone _____

**Provider signature** _____ Date _____