



# RITUXIMAB REFERRAL & ORDER SET

P: 331-236-0610 | F: 331-314-8989 Fax with insurance cards + clinical notes

## PATIENT INFORMATION

|                         |                 |               |                     |
|-------------------------|-----------------|---------------|---------------------|
| PATIENT NAME            |                 | DATE OF BIRTH | PHONE               |
|                         |                 |               |                     |
| WEIGHT (lbs) — required | HEIGHT (inches) | ALLERGIES     | NEXT TREATMENT DATE |
|                         |                 |               |                     |

## REFERRING PROVIDER & INSURANCE

|                |                   |          |         |
|----------------|-------------------|----------|---------|
| PROVIDER NAME  | NPI #             | PHONE    | FAX     |
|                |                   |          |         |
| CONTACT PERSON | PRIMARY INSURANCE | POLICY # | GROUP # |
|                |                   |          |         |

## DIAGNOSIS ICD-10 required

|                                                                                                                                   |                                                                                                                   |                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> M05.79 <input type="checkbox"/> M06.09                     | <input type="checkbox"/> Microscopic polyangiitis <input type="checkbox"/> M31.7                                  |                                                                  |
| <input type="checkbox"/> Granulomatosis with polyangiitis <input type="checkbox"/> M31.30 <input type="checkbox"/> M31.31 (renal) | <input type="checkbox"/> Pemphigus vulgaris <input type="checkbox"/> L10.0 <input type="checkbox"/> Other — below |                                                                  |
| OTHER DIAGNOSIS                                                                                                                   | DIAGNOSIS DESCRIPTION                                                                                             | PATIENT STATUS                                                   |
|                                                                                                                                   |                                                                                                                   | <input type="checkbox"/> New <input type="checkbox"/> Continuing |

## THERAPY ORDER

|                                     |                                                                                                                                                                                                                                                                                                                                                                                                               |
|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Product</b><br><i>choose one</i> | <input type="checkbox"/> Infuse rituximab or a rituximab biosimilar as the patient's insurance requires. Preferred product determined after benefits investigation.<br><input type="checkbox"/> Do not substitute — infuse this product only: _____                                                                                                                                                           |
| <b>Dose</b>                         | <input type="checkbox"/> 1,000 mg <input type="checkbox"/> 375 mg/m <sup>2</sup> <input type="checkbox"/> 500 mg <input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                        |
| <b>Frequency</b>                    | <input type="checkbox"/> One-time dose <input type="checkbox"/> Weekly × 4 weeks <input type="checkbox"/> Every 6 months × _____ refill(s)<br><input type="checkbox"/> Day 0, repeat in 2 weeks, then repeat course every _____ weeks or _____ months × _____ refill(s)<br><input type="checkbox"/> Day 0, repeat in 2 weeks — one-time order, do not repeat the course <input type="checkbox"/> Other: _____ |
| <b>Other orders</b>                 | _____                                                                                                                                                                                                                                                                                                                                                                                                         |

## PREMEDICATION & LABS

|                         |                                                                                                                                                                                                                                                                                   |
|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Protocol premeds</b> | Solu-Medrol 100 mg IV, Tylenol 1,000 mg PO, Benadryl 50 mg PO/IV <input type="checkbox"/> Other: _____<br>Substitute diphenhydramine with: <input type="checkbox"/> Loratadine 10 mg PO <input type="checkbox"/> Cetirizine 10 mg PO <input type="checkbox"/> Cetirizine 10 mg IV |
| <b>Lab orders</b>       | Labs: _____ Frequency: _____ Drawn by: <input type="checkbox"/> Infusion center <input type="checkbox"/> Referring provider                                                                                                                                                       |

## REQUIRED SCREENING & MEDICAL NECESSITY insurance will deny without this — please complete

|                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Screening</b>                            | <input type="checkbox"/> CBC with platelets <input type="checkbox"/> Hepatitis B screening complete — <b>surface antigen and core antibody total (not IgM):</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Attached<br><input type="checkbox"/> Quantitative immunoglobulins (recommended, not required) <small>If hepatitis B is positive, attach documentation of medical clearance.</small>                                                                                             |
| <b>Step therapy</b><br><i>as applicable</i> | Contraindication, intolerance or failed trial of glucocorticoids? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Intolerance or failed trial of a rituximab biosimilar? <input type="checkbox"/> Yes <input type="checkbox"/> No Which: _____<br>Failed DMARD / NSAID / conventional therapy (MTX, leflunomide)? <input type="checkbox"/> Yes <input type="checkbox"/> No Which: _____<br>Failed at least one biologic (Humira, Enbrel, Stelara, Cimzia)? <input type="checkbox"/> Yes <input type="checkbox"/> No Which: _____ |
| <b>Prior biologic</b>                       | Last biologic: _____ Last dose received: _____ Washout before rituximab: _____ weeks                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Attach</b>                               | <input type="checkbox"/> Insurance cards <input type="checkbox"/> Medication list <input type="checkbox"/> Clinical notes <input type="checkbox"/> Labs / diagnostics <input type="checkbox"/> Other necessity: _____                                                                                                                                                                                                                                                                                                                        |

## SITE OF CARE & PROVIDER SIGNATURE Required — we cannot schedule without a signature

By signing this form and using our services, you authorize LIVbetter Infusions and its employees to act as your prior authorization and specialty pharmacy designated agent with medical and prescription insurance companies, and to select the preferred site of care for the patient.

|                                                                      |                      |       |
|----------------------------------------------------------------------|----------------------|-------|
| SITE OF CARE                                                         | IF OPTING OUT — CITY | STATE |
| <input type="checkbox"/> Opt out of LIVbetter selecting site of care |                      |       |
| PROVIDER SIGNATURE                                                   | PRINTED NAME         | DATE  |
| X                                                                    |                      |       |
| FOR LIVbetter USE ONLY — Brand dispensed: _____                      |                      |       |