Allergy, Asthma & Immunology Center, P.C.
Infusion Services
www.aaicenter.net
Iftikhar Hussain, MD

Fax Referrals To: (855) 891-2191
Have a Question? (855) 478-1528

RITUXAN® (RITUXIMAB)ORDER FORM

(- Required Fields)*

___ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

_____ New Referral _____ Order Renewal _____ Medication/Order Change
_____ Benefits Verification Only _____ Discontinuation Order

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: M F
ADDRESS:		PHONE:	
WEIGHT: LBS KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

RITUXAN ORDER*: _ **ICD-10*: ______________________________**

*(SELECT **ONE** OF THE FOLLOWING)*

_____ Dosing: 1000 mg IV on day 0, day 14, then repeat the course every ___ weeks

OR

_____ Other Dosing: _________ mg /m^2 IV weekly for 4 weeks

OR

_____ Other Dosing: _________ mg IV every_______________________________________

Physician Signature* ________________________________

Date*(Order is Valid for One Year)_____________________
Infusion will be administered per policy and protocols

REQUIRED DIAGNOSIS:

_____ Granulomatosis w/ Polyangiitis (GPA) Wegner's

_____ Microscopic Polyangiitis (MPA)

_____ Rheumatoid Arthritis

_____ Pemphigus Vulgaris

_____ Other_______________________

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocol)

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Clinical/Progress Notes supporting DX

_____ Current Medication List and H&P

_____ HepB Surf Ag (w/in 12 months)

_____ HepB Core Ab (w/in 12 months)

Last Infusion/Injection Date: ____________________

STANDING LAB ORDERS: _____ CMP _____ CBC

____ Labs to be drawn by Infusion Center Frequency ______________________________

NOTES/ADDITIONAL COMMENTS:

Locations:

-------Oklahoma-------

___ Tulsa

REVISION DATE- 04/2020