



## Rituxan (Rituximab) Patient Referral and Prescription Sheet

**Return Signed Rx via Fax to: 704.583.2130**

Date:	To:	From:		
Phone: <b>866.583.2140</b>	Fax:	Number of Pages:		
Patient Information				
<b>Patient Name:</b>	<b>DOB:</b>	<b>Height:</b>		
<b>Allergies:</b>			<b>Weight:</b>	
Medication Order				
<b>Rituximab:</b> <input type="checkbox"/> Rituximab: 375mg x _____ BSA (m <sup>2</sup> ) = _____ IV every _____ for _____ courses.  <input type="checkbox"/> Rituximab: _____			Refills	
-First Rituximab IV dose is to be administered in a controlled environment setting then subsequent doses in the home setting -Dilute Rituxan to a final concentration of 1 mg/mL - 4 mg/mL with either 0.9% Sodium Chloride, or 5% Dextrose				
Diagnosis	ICD-10	Diagnosis	ICD-10	
<input type="checkbox"/> Rheumatoid Arthritis	M06.9	<input type="checkbox"/> Wegener's Granulomatosis	M31.3	
<input type="checkbox"/> Chronic Lymphocytic Leukemia (CLL)	C91.10	<input type="checkbox"/> Pemphigus Vulgaris (PV)	L10.0	
<input type="checkbox"/> Non-Hodgkin's Lymphoma (NHL)	C85.9	Other:		
<input type="checkbox"/> Neuromyelitis Optica [Devic]	G36.0			
<b>IV Access Device:</b> <input type="checkbox"/> Peripheral <input type="checkbox"/> Central		<b>Lab order:</b> <input type="checkbox"/> CBC with diff <input type="checkbox"/> CMP <input type="checkbox"/> _____		
<b>Pre-medications:</b> <input type="checkbox"/> Diphenhydramine: _____ <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Acetaminophen: _____ <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Methylprednisolone: _____ <input type="checkbox"/> IV <input type="checkbox"/> Other pre-meds: _____		<b>If applicable, flush IV access device per KabaFusion protocol:</b>		
<input type="checkbox"/> <b>Hydration:</b> Infuse 500 mL of Normal Saline with Rituximab infusion  <input type="checkbox"/> <b>Anaphylaxis Protocol: Epinephrine Auto-Injector dual pack:</b> <u>Adult:</u> 0.3 mg <u>Children:</u> 0.15 mg Administer epinephrine IM in the event of anaphylaxis. May repeat x 1 as needed, Call 911. <b>Refill x 1yr</b>		Access	NS	Heparin
		Peripheral	1-3 mL before/after use	10 U/mL 1-2 mL after last NS flush
		Midline, Central (non-port), PICC	5-10 ml before/after use 5-20 ml after blood draw	10 U/mL 3-5 mL after last NS flush 5 mL after the blood draw
		Implanted Port	5-10 mL before/after use. 20mL after blood draw	100 U/mL 5 mL after last NS flush 5 mL after the blood draw
		Tunneled	5-10 mL before/after use 20mL after blood draw	10 U/mL 3-5 mL after last NS flush 5 mL after the blood draw
		Groshong PICC, Midline	5-10 mL before/after use 10 mL after blood draw	None
I authorize KabaFusion and its representatives to act as an agent and initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to KabaFusion.				
Prescriber Signature: _____		Date: _____		
Print Prescriber Name: _____		NPI#: _____		
DOCUMENTATION – PLEASE FAX TO KABAFUSION				
<input type="checkbox"/> <b>Rx Order</b> – include dose, route of administration, frequency, duration, & pre-medications OR use the Rx order form above <input type="checkbox"/> <b>Patient Demographics</b> – include <b>insurance</b> information. <u>We will obtain authorization</u> unless the insurance dictates otherwise. <input type="checkbox"/> <b>H &amp; P OR progress note(s)</b> describing diagnosis, clinical status, and clinical symptoms. <input type="checkbox"/> <b>TB and Hepatitis B Virus (HBV) screening results</b> (required prior to Rituximab initiation) – <b>HBsAg and anti-HBc.</b> <input type="checkbox"/> Most recent lab results for: <b>BUN/Creatinine</b> (preferred within last 90 days), <b>CMP Panel and CBC with Differential</b>				

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