TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

RITUXIMAB

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ DEA: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
BIN: _____ PCN: _____

Secondary Insurance (If Applicable):
Secondary Insurance: _____
Plan #: _____
Group #: _____
BIN: _____ PCN: _____

CLINICAL INFORMATION

Primary ICD-10 Code: _____ Diagnosis Description: _____
Secondary ICD-10 Code: _____ Diagnosis Description: _____
Hepatitis B Vaccination: ☐ Yes ☐ No Patient on Methotrexate: ☐ Yes ☐ No Line Access: ☐ PIV ☐ Port ☐PICC ☐ Midline

RITUXIMAB ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Dose: _____

Medication	Dose/Frequency	Refills
☐ Rituxan® (Rituximab) 100mg/10ml Vial ☐ Rituxan® (Rituximab) 500mg/50ml Vial	☐ 1000mg IV x 2 Doses separated by 14 days, repeat every 24 weeks ☐ Other: _____ Frequency:_____	_____
☐ Riabni™ (rituximab-arrx) 100mg Vial ☐ Riabni™ (rituximab-arrx) 500mg Vial	☐ 375mg/m2 once weekly for 4 weeks ☐ 500mg IV infusion separated by 2 weeks, followed by a 500mg IV infusion every 6 months ☐ Other: _____ Frequency:_____	_____
☐ Ruxience® (Rituximab-pvvr) 100mg Vial ☐ Ruxience® (Rituximab-pvvr) 500mg Vial	☐ 1000mg IV x 2 Doses separated by 14 days, repeat every 24 weeks ☐ Other: _____ Frequency:_____	_____

Pre-Medication	Dose/Strength	Directions
☐ Acetaminophen	☐ 500mg	☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed
☐ Cetirizine	☐ 10mg	☐ Take 1 tablet PO prior to infusion or as directed
☐ Diphenhydramine	☐ 25mg IV/PO ☐ 50mg IV/PO	☐ Take 1 tablet PO prior to infusion or as directed OR ☐ Inject contents of 1 vial IV prior to infusion or as directed
☐ Methylprednisolone	☐ 40mg ☐ 100mg ☐ 125mg	☐ Inject contents of 1 vial IV prior to infusion or as directed ☐ Other: Inject 100mg IV 30 minutes prior to infusion
☐ Ondansetron ODT	☐ 4mg	☐ Take 1-2 tabs prior to infusion or as directed
☐ _____	_____	_____

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SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X_____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.