



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ DEA: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)	
Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Secondary Insurance: _____
Group #: _____	Plan #: _____
RX Card (PBM): _____	Group #: _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION			
Primary ICD-10 Code: _____	Diagnosis Description: _____		
Secondary ICD-10 Code: _____	Diagnosis Description: _____		
Hepatitis B Vaccination: <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient on Methotrexate: <input type="checkbox"/> Yes <input type="checkbox"/> No	Line Access: <input type="checkbox"/> PIV <input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> Midline	

RITUXIMAB ORDERS	
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy	Total Doses Received: _____ Date of Last Dose: _____

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

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

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.



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)

## 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.

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