

LAWRENCE COUNTY
Memorial  Hospital
DEACONESS ILLINOIS PARTNER

| PATIENT INFORMATION | | |
|--|---|---------------|
| Name: | DOB: | |
| Allergies: | Date of Referral: | |
| REFERRAL STATUS | | |
| <input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal | | |
| DIAGNOSIS AND ICDE 10 CODE | | |
| <input type="checkbox"/> Rheumatoid Arthritis (RA) | ICD 10 Code: M05.9 | |
| <input type="checkbox"/> Chronic Lymphocytic Leukemia (CLL) | ICD 10 Code: C91.10 | |
| <input type="checkbox"/> Other: _____ | ICD 10 Code: _____ | |
| REQUIRED DOCUMENTATION (referral will not be processed without the required documentation) | | |
| <input type="checkbox"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number *Pt may be required to submit a pregnancy test prior to treatment | <input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> labs and tests supporting primary diagnosis <input type="checkbox"/> Hepatitis B results: HBsAg and Total HepB Core Antibody (within 1 year) | |
| List of tried and failed therapies, including duration of treatment: | | |
| 1) _____ | | |
| 2) _____ | | |
| MEDICATION ORDERS | | |
| Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____ | | |
| Initial Dosing | <input type="checkbox"/> J9312 Rituxan 100mg IV every 14 days for two doses ONLY <input type="checkbox"/> J9312 Rituxan 100mg IV every 14 days for two doses, Repeat every 6 months <input type="checkbox"/> J9312 Rituxan 100mg IV once <input type="checkbox"/> J9312 Rituxan 375mg/m ² IV every _____ <input type="checkbox"/> Other: J9312 Rituxan _____ | |
| Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses | | |
| PREMEDICATIONS/ LAB ORDERS | | |
| <input type="checkbox"/> Acetaminophen _____ mg PO PRN <input type="checkbox"/> CBC <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> Benadryl _____ mg PO or IV <input type="checkbox"/> CMP <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> Other: _____ Date: _____ <input type="checkbox"/> Other: _____ | | |
| ADDITIONAL ORDERS/INFORMATION | | |
| | | |
| PRESCRIBER INFORMATION | | |
| Provider Name: | | |
| Office Phone: | Office Fax: | Office Email: |
| Prescriber Signature: | Date: | Time: |

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
 FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS – RITUXAN (RITUXIMAB)