O·S·M·S
ORTHOPEDIC & SPORTS MEDICINE SPECIALISTS

RHEUMATOLOGY & INFUSION THERAPY CLINIC
Green Bay • Fox Valley • Marinette • Oshkosh
Phone: 920-430-8113 • Infusion Fax: 920-965-6389
osmsgb.com

Rituximab/Biosimilar (Any rituximab product as required by the patients' health plan*)

*Rituximab products include: Rituxan, Ruxience, Truxima, Riabni

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: ☐ Green Bay ☐ Neenah ☐ Marinette

PATIENT INFORMATION

Date: Patient Name: DOB:

☐ NKDA Allergies: Weight:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Office Contact Name: Office Email:

Prescribing Providers Name: Provider NPI:

Office Address: City: State: Zip:

Office Phone Number: Office Fax Number:

DIAGNOSIS AND ICD 10 CODE

☐ Rheumatoid Arthritis (RA) ICD 10 Code: M06.9

☐ Granulomatosis with polyangiitis ICD 10 Code: M31.30

☐ Other: _____ ICD 10 Code: _____

REQUIRED DOCUMENTATION

☐ This signed order form by the provider
☐ Patient demographics AND insurance information (copy of cards)
☐ Clinical/Progress notes
☐ Lab and Tests supporting primary diagnosis
☐ Hepatitis B Test Results: HBsAg, Total HepB Core Antibody
☐ Hepatitis C Test Results
☐ Immunoglobulin Lab Results
☐ TB Test Results

List Tried & Failed Therapies, including duration of treatment:

1.
2.
3.

PREMEDICATION ORDERS

☐ Acetaminophen (Tylenol) PO ☐ 500mg ☐ 1000mg

☐ Diphenhydramine (Benadryl) **PO / IV** ☐ 25mg ☐ 50mg (if route is not circled PO will be administered)

☐ Methylprednisolone (Solu-Medrol) IV ☐ 125mg ☐ 62.5mg

☐ Fexofenadine (Allegra) PO ☐ 180mg

MEDICATION ORDERS (order will expire in 1 year unless otherwise specified)

■ Provider will select product (chosen based on patient's insurance coverage and availability)

Dosing

☐ Rituxan 1000mg IV every 14 days for two doses ONLY
☐ Rituxan 1000mg IV every 14 days for two doses; Repeat every 6 months
☐ Rituxan 1000mg IV once
☐ Rituxan 375 mg/m^2 IV every _____
☐ Other: Rituxan _____

Refills:

☐ X6 months
☐ X1 year
☐ _____ doses

Please note: If an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion, or discontinuing the medication.

LAB ORDERS

☐ CBC w/ diff ☐ CMP ☐ CRP ☐ ESR ☐ Vitamin D OH Total ☐ Hep B Surface Antigen ☐ Quantiferon TB Gold ☐ Other:
☐ w/ every infusion ☐ w/ every other infusion ☐ Other:

Provider Name (Print) **Provider Signature:** **Date:**

Fax Referral to 920-965-6389

All information contained in this order form is strictly confidential and will become a part of the patient's medical record.