



Please Fax Completed Form To: 888-340-3699

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

Please Send a Copy of The Patient's Up-to-Date Clinical Notes

PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____	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: <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"/> 25mg	<input type="checkbox"/> Take 1-2 tablets PO prior to infusion or post-infusion as directed
<input type="checkbox"/> Diphenhydramine	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"/> _____	_____	_____

INFUSION REACTION ORDERS

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Mild reaction protocol:

Diphenhydramine 25mg IV, one time, for pruritus.

If symptoms worsen, see orders for moderate to severe reactions.

Moderate reaction protocol:

Acetaminophen 650mg PO, one time, for pyrexia or rigors

Diphenhydramine 50mg IV, one time, for pruritus or urticaria

Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms

If symptoms worsen, see interventions for severe reactions

Severe reaction protocol: (Call 911 if initiated):

Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)

Diphenhydramine 50mg IV, one time, for respiratory symptoms, edema, or anaphylaxis

Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms

Epinephrine 0.3mg/0.3mL IM into mid-antrolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

FLUSHING & LOCKING ORDERS

Flushing Protocol (>66lbs/33kg)

PIV and Midline:

0.9% Sodium Chloride 2-5mL IV flush before and after each infusion

Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:

0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw

Locking Protocol (>66lbs/33kg)

PIV and Midline:

Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush

PICC:

Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush

Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:

Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush

**** May substitute Dextrose 5% in Water, or alternative, for 0.9% Sodium Chloride, when indicated due to incompatibility with medications being infused**

SIGNATURE

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

X _____

Prescriber Signature

Date: _____

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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