CLINICAL SPECIALTY INFUSIONS

Phone: 833-569-1005 | Fax: 430-200-4889 | Online: deliver.myforcura.com

RITUXIMAB ENROLLMENT FORM

Account manager: _____ Contact info: _____

✂ AZ: Please detach before submitting to a pharmacy.

PATIENT INFORMATION

Patient Name:		Caregiver (if applicable):	
Address:	City:	State:	Zip:
Main Phone:	Alternate Phone:	Email:	Last 4 of SSN (required):
Date of Birth:	☐ Male or ☐ Female	Height (required): _____ ☐ cm or ☐ inches	Weight (required): _____ ☐ lb or ☐ kg

CLINICAL INFORMATION

Primary ICD-10 Code:	Is patient currently on therapy? ☐ Yes ☐ No	Allergies:	Is this a female patient of childbearing age? ☐ Yes ☐ No

REQUIRED: Dates of the TWO Rituximab doses received & well tolerated in controlled setting: Date 1: _____ Date 2: _____

REQUIRED: Hep B lab results ☐ Yes ☐ No ☐ Pending HBsAG:_____ anti-HBc:_____ Test Date: _____

RECOMMENDED: Has the patient been tested for JCV antibodies? ☐ Yes ☐ No ☐ Pending Result:_____ Test Date: _____

Please include face sheet, copy of insurance cards (front and back), H&P, clinicals and any available lab results.

PRESCRIPTION AND ORDERS

Medication	Dosing		Quantity	Refills
☐ **Rituximab®** (Rheumatoid Arthritis (RA))	**Induction (controlled setting):** ☐ Adults: 1000 mg IV at 0 & 2 weeks ☐ Other: _____	**Maintenance:** ☐ Adults: 1000 mg IV x 2 doses separated by 2 weeks every 16-24 weeks ☐ Other: _____	☐ 2 doses for induction, no refills ☐ 2 doses for maintenance ☐ Other: _____	x 1 year unless noted otherwise: ☐ _____refills
☐ **Rituximab®** (Myasthenia Gravis (MG))	**Induction (controlled setting):** ☐ Adults: 1000 mg IV at 0 & 2 weeks ☐ Other: _____	**Maintenance:** ☐ Adults: 1000 mg IV every 6 months after induction ☐ Other: _____	☐ 2 doses for induction, no refills ☐ 6-month supply for maintenance ☐ Other: _____	x 1 year unless noted otherwise: ☐ _____refills
☐ **Rituximab®** (Pemphigus Vulgaris (PV))	**Induction (controlled setting):** ☐ Adults: 1000 mg IV at 0 & 2 weeks ☐ Other: _____	**Maintenance:** ☐ Adults: 500 mg IV at month 12, then every 6 months Relapse: Adults 1000 mg IV	☐ 2 doses for induction, no refills ☐ 6-month supply for maintenance ☐ 1 dose for relapse, no refill	x 1 year unless noted otherwise: ☐ _____refills

Medication Specific Infusion and Administration:
First Infusion: Initiate rate at 50 mg/hr, increase infusion rate by 50 mg/hr increments every 30 minutes, to a maximum of 400 mg/hr. Based on patient tolerability. Nursing refer to prescription label for patient specific infusion rates.
Subsequent Infusions: Initiate rate at 100 mg/hr, increase rate by 100 mg/hr increments at 30-minute intervals, to a maximum of 400 mg/hr.Based on patient tolerability. Nursing refer to prescription label for patient specific infusion rates.

Labs:

Premedication 30 minutes prior to infusion:
- Acetaminophen 500-1000 mg PO, dispense x 1 bottle (refill x 1 year)
- Diphenhydramine 25-50 mg PO, dispense x 1 bottle (refill x 1 year)
- Solumedrol 100 mg slow IV push, dispense x 1 vial (refill x 1 year)

Adverse/Anaphylactic Reactions, per protocol (Intravenous): dispense ana-kit x 1 (refill x 1 year)
- Epinephrine 1:1000, 1 mL vial x 1
- Diphenhydramine 50 mg/1 mL vial x 1
- Diphenhydramine 50 mg tab/cap x 1
- 0.9% Sodium Chloride 500 mL bag x 1

PRN: ☐ Other: _____

Nursing Orders for Home Infusion: Provide skilled nursing for home medication administration as prescribed and per CSI nursing policies. Insert, access, and manage vascular access devices. Deliver nursing care for therapy duration and educate patient on medication, disease state, adverse reactions, and administration. Monitor patient response and report adverse events.

Flush Orders: Flush with 0.9% sodium chloride 5-10 mL pre and post medication and as needed, max per dispense x 60 syringes (refill x 1 year). For CVADs ONLY, may add Heparin 3-5 mL as final flush to maintain patency as needed; PORT 100 units/mL; PICC 10 units/mL, max per dispense x 30 syringes (refill x 1 year).

PRESCRIBER INFORMATION

Prescriber Name:		Practice Site Name:	
Address:	City:	State:	Zip:
NPI:	Phone:	Fax:	
Office Contact and Special Instructions:			

Prescriber Authorization: I authorize the pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's Signature: **Date:**

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CSI CLINICAL SPECIALTY INFUSIONS

Pre-authorization Checklist

HELP US SPEED AUTHORIZATION FOR TREATMENT.

Please use this checklist to ensure all necessary documentation is submitted to support initial authorization of immune globulin (Ig) therapy:

PLEASE INCLUDE ON BEHALF OF THE PATIENT (IF AVAILABLE):

- Completed referral form
- Insurance information (copy of insurance card/s preferred)
- Last two office visit notes to include current symptoms and tried/failed therapies
- Labs or diagnostic evidence supporting indication (e.g., EMG/NCS, spinal tap or lumbar puncture, MRI, nerve and/or muscle biopsy, antibody testing)
- History of failure, contraindication or intolerance to other treatments (e.g., PLEX, corticosteroids, immunosuppressants)
- Required Hepatitis B Labs; Hepatitis B surface antigen (HBsAg) and Hepatitis B Core Antibody (anti-HBc)

ADDITIONAL HELPFUL CLINICAL INFORMATION IF AVAILABLE:

Rheumatoid Arthritis

- MRI/Ultrasound
- Anti-CCP Antibodies
- Rheumatoid Factor (RF)
- Erythrocyte Sedimentation Rate (ESR)
- C-Reactive Protein (CRP)
- T/F therapies

Myasthenia Gravis (MG) (with or without acute exacerbation)

- Tensilon Test (if done)
- MG-ADL score worksheet, documentation of current condition (shortness of breath, swallowing difficulty, overwhelming fatigue, etc.)
- Lab Work/Antibody testing
- Recent (within the last month) chart notes documenting symptoms of exacerbation (if applicable).
- T/F therapies (immunosuppressants, corticosteroids)

Pemphigus Vulgaris

- Positive direct immunofluorescence (DIF) microscopy result
- Autoantibodies as detected by indirect immunofluorescence (IIF) or enzyme-linked immunosorbent assay (ELISA)
- Tzanck Smear
- T/F therapies