Sarah Bush Lincoln

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Rheumatoid Arthritis (RA)	ICD 10 Code: M06.9
☐ Chronic Lymphocytic Leukemia (CLL)	ICD 10 Code: C91.10
☐ Other Diagnosis:	ICD 10 Code: _____

REQUIRED DOCUMENTATION

☐ This signed order form by the provider	☐ Clinical/Progress notes supporting primary diagnosis
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
	☐ Hepatitis B Test Results: HBsAg & Total HepB Core Antibody

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

Initial Dosing **J9312**	☐ 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 375mg/m² IV every _____ ☐ Other: Rituxan _____

Refills*: ☐ **None** ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

PREMEDICATIONS

☐ Acetaminophen 650mg PO, 30-60 minutes prior to rituximab infusion
☐ Diphenhydramine 25mg PO, 30-60 minutes prior to rituximab infusion
☐ Methylprednisolone 100mg Slow IV Push, 30 minutes prior to infusion
☐ Other: _____

ADDITIONAL ORDERS

PRESCRIBER INFORMATION

Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

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

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Suite 204
Mattoon, IL 61938
Ph. 217-258-4150
Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr. Suite 201
Effingham, IL 62401
Ph. 217-342-7500
Fax 217-342-7499

INFUSION ORDERS - RITUXAN (RITUXIMAB)

Clinics Scan to: Physician Orders