



Select referral location:

Akron	Columbus (East Broad)	Findlay	Toledo
Athens	Columbus (Hilliard)	Liberty	Crestview Hills (NKY)
Cincinnati (Blue Ash)	Columbus (Worthington)	Mansfield	
Cincinnati (West)	Dayton (Beavercreek)	Perrysburg	
Cleveland	Dayton (Englewood)	Springfield	

Rituxan Order Form

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to 888-977-0914

Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	DOB:
Phone:	Other Phone:
Email:	
Social Security #:	Allergies:
Gender: M F	Weight: Lbs Kg
Patient Status: New to therapy Continuing therapy	Next due date (if applicable):

2. INSURANCE INFORMATION (required)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:	NPI#:
License #: TIN#:	DEA#:
Address:	
City:	State Zip
Office Contact:	Email:
Office phone:	Office fax:

4. DIAGNOSIS INFORMATION (and year of diagnosis) - Hep B and TB required prior to initial infusion

Rheumatoid Arthritis ()	Pemphigus Vulgaris (PV) ()	ICD 10 ()
Granulomatosis with Polyangitis (GPA) ()	Microscopic Polyangitis (MPA) ()	Other: _____

5. PRESCRIPTION INFORMATION (requires new order every 12-months)

RITUXAN	RUXIENCE	TRUXIMA	PRE-MEDICATIONS	N/A
Initial	Maintenance		Acetaminophen	500mg 650mg 1000mg
Administer 1000mg at Day 1 and Day 15; Repeat every _____ weeks			Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
First infusion in series: 50mg/hr, increasing every 30 minutes by 50mg/hr to maximum of 400mg/hr			Diphenhydramine (Benadryl)	25mg 50mg PO IV (requires driver)
Subsequent infusion in series: 100mg/hr, increasing every 30 minutes by 100mg/hr to maximum of 400mg/hr			Methylprednisolone (Solu-Medrol)	40mg 80mg 125mg IV
Vital signs per HI protocol			Prednisone _____ mg PO	
Anaphylaxis & Hydration Management per HI protocol			Other _____	
			POST-MEDICATIONS	N/A
			Acetaminophen	500mg 650mg 1000mg
			Prednisone _____ mg PO	
			Other _____	

6. LABS

CBC w/Diff	Each Infusion	Other Frequency (specify): _____
CRP	Each Infusion	Other Frequency (specify): _____
CMP	Each Infusion	Other Frequency (specify): _____
ESR	Each Infusion	Other Frequency (specify): _____
Hepatic Panel	Each Infusion	Other Frequency (specify): _____
Renal Panel	Each Infusion	Other Frequency (specify): _____
Quantiferon TB Gold, annually, last completed (date):	_____	
Other (specify):	_____	

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE