Rituximab (Rituxan®) Order Form **FAX to 1 (888) 797-4008**

PATIENT INFORMATION		
Patient Name:		DOB:
Address:		
City:	State:	Zip code:
Patient's phone number:		
Is patient a Wayne Health patient registered in athena?		

Order date:	Weight:	Height:
Drug allergies: NKDA. YES. Please specify.		
ICD-10 diagnosis:		

LABORATORY DATA			
CBC:	BMP:	Serology:	
Other:			
Hepatitis Screen			
HBsAg: ☐ Pos ☐ Neg	HBsAb: ☐ Pos. ☐ Neg	HBcAb: ☐ Pos. ☐ Neg	Date:

RITUXIMAB (Rituxan®)	
☐ 1000 mg IV day #1 and day #15	☐ 500 mg IV q 6 months starting day #30
☐ Other:	Refills:

ORDERING PHYSICIAN INFORMATION	
Name:	NPI:
Address:	
Phone number:	Fax number:
Physician signature:	Date:

To ensure payment by insurance carrier, please include with faxed order form supporting clinical documentation for specified ICD 10 Code, demographic and insurance information. Initial appointment will be verified upon insurance approval.