



MOUNTAIN GRACE
— HOME INFUSION —

+1 833-360-1212 info@mginfusion.com

+1 (760) 400-6905

RITUXAN

(Or other rituximab products as required by the patient's health plan)

Date of order: _____

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Update Order ☐ Order Renewal

Date: _____ Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): ☐ M05. ____ ☐ M06. ____ ☐ M31.30 ☐ M31.31 ☐ M31.7 ☐ L10.0 ☐ Other _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: info@managecaresolutions.com

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

- ☒ Deliver patient care in accordance with Mountain Grace Home Infusion clinical procedures and the medication's prescribing information (PI), including the recognition, monitoring, and appropriate management of hypersensitivity reactions.
- ☒ Hep B (HBsAg and anti-HBc) Test Results
- ☒ CBC with diff and platelets

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
 - ☐ CMP ☐ at each dose ☐ every _____
 - ☐ Other _____ ☐ Frequency _____
- ☐ Please check this box if you DO NOT authorize Mountain Grace Home Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

- ☒ Rituxumab Intravenous Infusion
 - Dose:** ☐ 500mg ☐ 1,000mg ☐ Other: _____
 - Frequency:**
 - ☐ On Day 0 and Day 14; repeat every ____ weeks.
 - ☐ Other _____
 - ☐ Refills: ☐ Zero/ ☐ for 12 months/ ☐ _____
(if not indicated order will expire one year from date signed)
- To receive the brand-name medication, the prescribing provider must clearly write "Brand Medically Necessary" on the prescription. If this notation is absent, I4H may dispense an FDA-approved generic equivalent or biosimilar, when available.*

PRE-MEDICATION ORDERS

Patients are recommended to receive premedication with acetaminophen, an antihistamine, and methylprednisolone (or an equivalent corticosteroid) approximately 30 minutes prior to each infusion, as directed by the prescribing provider and medication prescribing information (PI).

☐ Diphenhydramine ☐ 25mg ☐ 50 mg ☐ PO ☐ IV

☐ Acetaminophen ☐ 325mg ☐ 500mg ☐ 650 mg ☐ PO

☐ Methylprednisolone ☐ 40 mg ☐ 125 mg ☐ IV

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:

Provider Name (Print) : _____

Provider Signature : _____

Date : _____

Please send it to this email: info@mginfusion.com