PURE
INFUSION SUITES

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Salt Lake City - 1.801.852.0999

Note: you must enter a 1 before the fax number

INFUSION ORDERS TRUXIMA (biosimilar to rituxan)

Patient's Information

Date of Referral

First Name | Last Name | M.I.

Date of Birth

Address

City | State | ZIP Code

Phone

WT (kg) | HT (in)

Diagnosis

Allergies

***Please fax all recent labs including TB date/results and Hepatitis B date/results.**

*ICD 10 CODE

*** Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval**

FOLLOWS RITUXAN DOSING

☐ Rituxan dose of 1,000 mg IV

☐ Rituxan specific dose of

Refills:

Frequency

☐ 2 doses of 1,000 mg IV every 2 weeks

☐ Specific dosing frequency of

Premedications

Prescribing Provider

Address

City | State | ZIP Code

Provider Signature

Date

Provider Phone | Provider Fax