

INFUSION ORDERS RUXIENCE (biosimilar to rituxan)

you must enter a 1 before the fax number

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 RUXIENCE DOSING

Ruxience dose of 1,000 mg IV

Ruxience 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/Time

Provider Phone Provider Fax