

Rituximab

(including Rituxan and biosimilars: Riabni, Ruxience, Truxima)

Provider Order Form rev. 1/12/2026



PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Full Name: _____ DOB: _____ Phone: _____ Gender: M F Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? Yes, (Send a copy) No (AIC will process)

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

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

- D59.10 Autoimmune hemolytic anemia, unspecified
- D89.1 Cryoglobulinemia
- I77.6 Arteritis, unspecified
- M05.10 Rheumatoid lung disease w/rheumatoid arthritis of unspecified site
- M05.79 Rheumatoid arthritis with rheumatoid factor multiple sites without organ system involvement
- M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified
- M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites
- M06.89 Other specified rheumatoid arthritis, multiple sites
- M06.9 Rheumatoid arthritis, unspecified

- M31.30 Wegener's granulomatosis without renal involvement
- M31.31 Wegener's granulomatosis with renal involvement
- M31.7 Microscopic polyangiitis
- N01.7 Rapidly progressive nephrotic syndrome with diffuse crescentic glomerulonephritis
- N03.2 Chronic nephritic syndrome with diffuse membranous glomerulonephritis
- N04.2 Nephrotic syndrome with diffuse membranous glomerulonephritis
- Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.

Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

- Acetaminophen (Tylenol) 500mg 650mg 1000mg PO
- Cetirizine (Zyrtec) 10mg PO
- Loratadine (Claritin) 10mg PO
- Diphenhydramine (Benadryl) 25mg 50mg PO IV
- Methylprednisolone (Solu-Medrol) 40mg 125mg IV
- Other: _____ Dose: _____ Route: _____

Lab Orders

Required: Hep B Panel: HBsAg, HBsAb (anti-HBs), HBCAb (anti-HBC)
 Other: _____

Rituximab (Select one):

Choose ONE of these two options:

Rituximab biosimilar (e.g., Ruxience™, Riabni, or Truxima®) as permitted by patient's insurance

- Preferred Product: Truxima Ruxience Riabni
- 1000mg OR _____ mg OR _____ mg/kg

Rituximab (Rituxan®)

- Infuse 375 mg/m² IV once weekly for _____ doses.
- Infuse 375 mg/m² IV on Day 1 of each chemotherapy cycle for up to _____ infusions.
- Infuse 1000 mg IV on Week 0 and Week 2.
- Other: _____

Frequency:

Infuse Single Dose

Infuse every week for 4 weeks total

Infuse initial dose at day 1 followed by 2nd dose on day 15, then repeat cycle every _____ months for one year

Other frequency: _____ for one year

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

Refills: zero 6 months 12 months _____ (Prescription valid for one year, unless otherwise indicated)

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

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

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print)

Provider Signature

Date

E: Referrals@americaninfusioncare.com

Americaninfusioncare.com

Greater Houston Area F: 832.510.7824 P: 832.800.3213

McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454

Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213

Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454