CureStat IS Infusion Services

Phone: (888) 963-6544
Fax: (858) 281-0045
CureStatInfusions.com
Pharmacy@CureStatRx.com

TRUXIMA

Please include the following to expedite the order:
Patient Demographics, Insurance Information, TB Test

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ **DOB:** _____ **Gender:** ☐ M ☐ F ☐ Other _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

PRESCRIBER

Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

CLINICAL

Diagnosis: ☐ C82.____ ☐ C83.____ ☐ C85.____ ☐ M05.____ ☐ M06.____ ☐ M31.____
☐ L10.0 ☐ Other: _____

Allergies: _____ **Weight:** _____ ☐ kg ☐ lbs **Height:** _____ ☐ cm ☐ in

TB/PPD test: ☐ Positive ☐ Negative **HBV:** ☐ Yes ☐ No If yes, treated: ☐ Yes ☐ No

CBC Completed: ☐ Yes ☐ No **CMP/LFTs Completed:** ☐ Yes ☐ No

TREATMENT

TRUXIMA (rituximab-abbs)

Route: Intravenous Infusion

Dose: ☐ 375mg/m²
☐ 500mg
☐ 1000mg
☐ Other: _____

Frequency:
☐ On day 0 and 14, repeat every _____ weeks
☐ Weekly for _____ doses
☐ Every 6 months
☐ Other: _____

Quantity: _____ **Refills:** _____

Premedication Protocol:

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO
☐ Methylprednisolone: ☐ 40mg ☐ 125mg IV
☐ Other: _____

Sig: _____

Center will use anaphylactic and hypersensitivity protocol established by Cure Stat Infusion Services.

Special Instructions: _____
_____
_____
_____

Provider Signature: _____ Date: _____

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