Northwest Rheumatology Associates, P.C.
9555 SW Barnes Road - Suite 150 – Portland, Oregon 97225
Telephone: (503) 297-3384 - Fax: (503) 297-0863
www.nwrheumatology.org

RITUXAN/BIOSIMILAR ORDER

Patient Name: _____ DOB: _____ Date: _____

Patient demographics, (address, phone) ❒

Copy front and back of all insurance cards ❒

Dose of Rituxan IV	Frequency of Doses
❒ 1000 MG	❒ Doses at day 1 and day 15 then Q 4-6 months thereafter

Prior to IV infusion/injection confirm the following:

❒ Patient weight: _____ lbs & _____ kgs

ICD-10 Code: _____

CPT Code: J9312

Expires one calendar year from date or: _____

Ordering physician signature: _____

Ordering physician printed name: _____

Ordering physician phone number: _____

Ordering physician fax number: _____

Please note all boxes must be checked off for us to schedule your patient for treatment. *Please fax this information to (503) 297-0863 Attn: Patient Resource Team. Please call with any questions at (503) 297-3384*