

*NPI* #\_

## AIC Nephrology Fax: 833-808-0833

Patient Information				
Patient Name:	DOB:	Height:	Weight:	Patient Contact #:
☐ D59.5 Paraxysmal☐ Other:  **Please include a demogra		PNH) □ M10 ——— an insurance car	0 Idiopath	
Allergies:				
☐ Diphenhydramine ☐ Alternate Oral Ant ☐ Methylprednisolor	□ 500mg □ 650mg - PO 30 m □ 25mg □ 50mg – PO 30 mir □ 25mg IVP □ 50mg IVP cihistamines: □ Cetirizine 10m ne □ 40mg IVP □ 125mg IVP g PO □ 40mg PO □ 20mg IV	nutes before infung   Loratadine or other m	ision. 10mg □ Fexof	enadine 60mg or □180mg
Labwork:	To be Drawn by:	☐ Infusion Clinic	☐ Referring Pro	ovider
Medication				
☐ Maintenance: Soli  Paroxysmal Nocturnal Her ☐ Induction: Soliris (	900mg IV every week x 4 dos ris 1200mg IV every 2 weeks	·		Maintenance Refills:
Rituximab (Rituxan & B. Preferred - Infusion C. Specific Product: Dosage: 1000mg IV per 5 Frequency: Infuse at 0 week a Infuse at 0 week a	iosimilars) Clinic Preference (Rituxan / 00ml sodium chloride 0.9% to and 2 weeks every 4 months (and 2 weeks every 6 months (2)	o infuse per prot 16 weeks) -or- 24 weeks)	cocol.	on payer directives / availability  Maintenance Refills:  e is recommended prior to infusion**
□ 8 mg per 250 ml soo	dium chloride 0.9% IV to info diphenhydramine IVP and me		e is recommen	ided prior to infusion**  Maintenance Refills:
<b>Physician Prescription O</b> Fax:	rders Address:  Clinic Contact:	Phys	ician Name:	Phone:

\_\_\_\_\_Physician Signature: \_\_\_\_\_\_Date: \_\_\_\_\_