☐ ***Borough Park***
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ ***Crown Heights***
555 Lefferts Avenue
Brooklyn, NY 11225

☐ ***Manhattan***
57W 57Street
Suite 601
New York, NY 10019

☐ ***Manhasset***
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ ***Rockville Centre***
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ ***Elmsford/ Terrytown***
555 Taxter Road
3rd Floor
Elmsford, NY 10523

☐ ***NYC Central Park West***
115 Central Park West
Suite 15
New York, NY 10023

☐ ***Woodbury***
75 Froehlich Farm
Woodbury, NY 11797

☐ ***Staten Island***
27 New Dorp Lane
Staten Island, NY 10306

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

☐ ***Manhattan***
225 E 70th Street
Suite 1E
New York, NY 10021

☐ ***Queens***
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ ***Manhattan***
225 East 70th Street
New York, NY 10021

☐ ***Holbrook/ Ronkonkoma***
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ ***Scarsdale***
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

☐ ***5 Towns***
141 Washington Avenue
Cedarhurst, NY 11559

☐ ***Long Beach***
917 Beech Street
Long Beach, NY 11561

☐ ***Riverhead***
1228 E Main Street
Suite A
Riverhead, NY 11901

☐ ***Bronx***
226 West 238th Street
Bronx, NY 10463

(rituximab)

RITUXAN infusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Rheumatoid Arthritis
☐ _____ Granulomatosis w/ Polyangitis
(wegener's granulomatosis GPA)
☐ _____ Microscopic Polyangitis
☐ _____ _____
(other)

PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ _____ *(other)*

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____ *(other)*

RITUXAN ORDERS

PATIENT WEIGHT

_____ lbs.
_____ kg

DOSAGE:
☐ 1000mg
☐ 375mg/m^2
Other_____

Frequency:
☐ Intial dose (0) followed by 2nd dose on day 15 ***(induction for RA diagnosis)***
☐ Single Dose
☐ Every week for 4 weeks total
_____
(other frequency)

☐ Total dosage ☐/refills_____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____