☐ *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

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

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

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

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

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

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

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

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

RITUXIMAB INFUSION ORDERS

Date: _____

PATIENT INFORMATION

☐ Demographics attached

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

J Code: J9312

Patient Weight: _____ lbs. Allergies: _____

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached

☐ **Required Labs:** CBC w/ platelet, Hepatitis B antigen, Hepatitis B core total antibody

☐ **Recommended Labs:** Quantitative immunoglobulins (IgM, IgG, and IgA), Hepatitis C Virus, TB Test

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

RITUXIMAB INFUSION ORDERS

SELECT BRAND: ☐ **RITUXAN** ☐ **TRUXIMA** ☐ **RUXIENCE**

Diagnosis: ☐ Rheumatoid Arthritis (ICD-10 _____) ☐ Other: _____ (ICD-10 _____)
(RA) **Dose:** ☐ 1000mg **Dose Frequency:** ☐ Day 0, repeat dose in 2 weeks
☐ One time dose

Diagnosis: ☐ Granulomatosis w/ Polyangiitis (ICD-10 _____) ☐ Microscopic Polyangiitis (ICD-10 _____)
(GPS/MPA) **Dose:** ☐ 375mg/m2 - **Dose Frequency:** ☐ weekly x 4 weeks ☐ Other: _____
☐ 500mg - **Dose Frequency:** ☐ Day 0, repeat dose in 2 weeks ☐ Other: _____

Diagnosis: ☐ Pemphigus Vulgaris (ICD-10 _____)
(PV) **Dose:** ☐ Initial Dose: 1000mg IV **Dose Frequency:** ☐ Day 0, repeat dose in 2 weeks
☐ Maintenance Dosing: 500mg IV ☐ Every 6 months

Diagnosis: ☐ Other: _____ (ICD-10_____)
(Other) ☐ Other: _____ (ICD-10_____)
Dose: ☐ 1000mg ☐ 500mg ☐ 375mg/m2 ☐ Other: _____
Dose Frequency: ☐ One Dose ☐ Day 0, repeat dose in 2 weeks ☐ Other: _____

Protocol Pre-Medication: Solu-Medrol 100mg IV, Tylenol 1000mg PO, Benadryl 50mg PO/IV
☐ Other: _____

Order Frequency: ☐ One time order, no refills
☐ Repeat ordered dose every _____ week(s) **OR** _____ month(s) **X** _____ dose(s)

Additional Orders/Comments:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____