TN
100 Covey Drive
Suite 307
Franklin, TN 37067

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

REJUVEINATE

Provider Order Form

Date: _____

Rituximab (Rituxan,Truxima,Ruxience)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

ICD-10 code (required): ICD -10 description:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

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

REFERRAL STATUS

○ New Prescription
○ Order Renewal
○ Does or Frequency Change
○ Discontinuation

PRE-MEDICATION ORDERS

The following are manufacturer recommended premedication regimens:

☐ acetaminophen (Tylenol) ☐500mg / ☐650mg / ☐1000mg PO
☐ methylprednisolone (Solu-Medrol) ☐40mg / ☐125mg IV
☐ diphenhydramine (Benadryl) ☐25mg / ☐50mg ☐PO / ☐IV
☐ other_____

ADDITIONAL PRE -MEDICATION ORDERS

☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ Other:_____
Dose:_____ Route:_____
Frequency:_____

SPECIAL INSTRUCTIONS

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

THERAPY ADMINISTRATION

Please check preferred product:
☐ Rituximab(Rituxan) ☐ Rituximab-abbs (Truxima)
☐ Rituximab-pvvr (Ruxience)

☑ Mix in 0.9% sodium chloride or D5W to final concentration of 1-4mg/ml
- Dose: ☐ 1000mg /☐ _____mg ☐ mg / kg
- Mix in: ☐ 500ml /☐ 250ml ☐ other _____
- Frequency: ☐ On Series Day 0 and Series Day 14; repeat series every 24 weeks
  ☐ Other: _____
- Infusion rate: First infusion in series: 50mg/hr, increasing every 30 minutes by 50mg/hr to maximum of 400mg/hr
- Subsequent infusion in series: 100mg/hr, increasing every 30 minutes by 100mg/hr to maximum of 400mg

☑ Flush with 0.9% sodium chloride at the completion of infusion
☑ Monitor patient for 30 minutes post infusion
☐ Refills: ☐ Zero /☐ for 12 months /☐ _____
(if not indicated order will expire one year from date signed)
☐ total dosage _____ ☐ refill _____

Pre-medicate patients with an antihistamine and acetaminophen prior to dosing. For RA and PV patients, methylprednisolone 100 mg intravenously or its equivalent is recommended 30 minutes prior to each infusion.Screen all patients for HBV infection by measuring HBsAg and anti- HBc before initiating treat ment with RITUXAN. For patients who show evidence of prior hepatitis B infection (HBsAg positive [regardless of antibody status] or HBsAg negative but antiHBc positive), consult with physicians with expertise in managing hepatitis B regarding monitoring a nd consideration for HBV antiviral therapy before and/or during RITUXAN treatment.

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone_____ Fax _____