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333 East Shore Road
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Manhasset, NY 11030

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

Elmsford/Tarrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

NYC Central Park West
115 Central Park West
Suite 15
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Woodbury
75 Froehlich Farm
Woodbury, NY 11797

Staten Island
27 New Dorp Lane
Staten Island, NY 10306



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225 E 70th Street
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233 Union Ave
Suite 207
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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

Provider Order Form

Rituximab (Rituxan, Truxima, Ruxience)

Date: _____

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) Rituximababbs (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: OnSeries 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 treatment 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 and consideration for HBV antiviral therapy before and/or during RITUXAN treatment.

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____