Vermont
28 Park Ave
Suite #1A
Williston, VT 05495

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

Mission Medical

(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 _____