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

Mission Medical

Lancaster
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

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:

PRE-MEDICATION ORDERS

The following are manufacturer recommended premedication regimens:

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

ADDITIONAL PRE-MEDICATION ORDERS

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

REQUIRED DOCUMENTATION CHECKLIST:

☐ _____ Patient Demographics
☐ _____ Insurance Card/Information
☐ _____ Recent Progress note
☐ _____ Recent labsto include Hepatitis panel, CBC, CMP as well quantitative, if available.
***Please send any other recent labs**

_____ Other

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)

☐ **Dose:** ☐ 1000mg **OR** _____ mg **OR** _____ mg/kg

FREQUENCY: ☐ One time Dose **OR**
☐ On Week 0 THEN WEEK 2;
☐ **NO** refills **OR**
repeat series every:
☐ 16 Weeks
☐ 24 Weeks
☐ 26 Weeks
☐ Weekly x_____ TOTAL doses
☐ Other:_____

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 _____