Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Forest Hills
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

Sheepshead Bay
2546 East 17th Street
Fl, 1
Brooklyn, NY 11235

Long Island City
36-36 33rd
Suite 311
Long Island City, NY, 11106

Bronx
226 West 238th Street
Bronx, NY 10463

Massapequa
97 Grand Avenue
Massapequa, NY 11758

NYC

E 56th & Park Midtown
120 East 56 Street
Suite 300
New York, NY 10022

E 70th St Upper East Side
225 E 70th Street
Suite 1E
New York, NY 10021

FIDI
30 Broad Street
Suite 401
New York, NY 10004

Central Park West
115 Central Park West
Suite 15
New York, NY 10023

Gramercy
7 Gramercy Park West
Lower Level
New York, NY, 10003

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

Mission Medical

Tarrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Port Jefferson
12 Medical Drive
Suite B
Port Jefferson Station, NY 11776

Staten Island
27 New Dorp Lane
Staten Island, NY, 10306

Southampton
625 Hampton Road
Southampton, NY 11968

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Holbrook
233 Union Avenue
Suite 207
Holbrook, NY 11741

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

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

New Hyde Park
1991 Marcus Ave
Suite 110
Lake Success, NY, 11042

Woodbury
7600 Jericho Tpke,
Lower Level, Suite C500
Woodbury NY 11797

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 _____