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ThrIVewell™ INFUSION
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Mission Medical

Provider Order Form

RITUXIMAB

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:

RITUXIMAB IV BRANDS:

☐ **Rituxan** ☐**Truxima** ☐ **Ruxience**

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:_____

If the medication selected above is not covered or is non-preferred by the patient's insurance, the prescribing provider authorizes consideration of the clinically appropriate alternatives listed below. Final medication selection will be based on provider clinical judgment and/or payer requirements. Provider signature below confirms authorization for the above substitution(s), if applicable.

RITUXIMAB IV BRANDS: ☐ **Rituxan** ☐**Truxima** ☐ **Ruxience**

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____