

Lexington
1792 Alysheba Way
Suite 205
Lexington, KY 40509

Bowling Green
727 U.S. 31 W Bypass
Suite 102
Bowling Green, KY 42101



Provider Order Form

RITUXIMAB

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Referral Renewal
<input type="checkbox"/> Medication/Order Change	<input type="checkbox"/> Benefits Verification Only
<input type="checkbox"/> 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:
<input type="checkbox"/> Rituxan <input type="checkbox"/> Truxima <input type="checkbox"/> Ruxience

PRE-MEDICATION ORDERS
<i>The following are manufacturer recommended premedication regimens:</i>
<input type="checkbox"/> acetaminophen (Tylenol) <input type="checkbox"/> 500mg / <input type="checkbox"/> 650mg / <input type="checkbox"/> 1000mg PO
<input type="checkbox"/> methylprednisolone (Solu-Medrol) <input type="checkbox"/> 125mg IV
<input type="checkbox"/> diphenhydramine (Benadryl) <input type="checkbox"/> 25mg / <input type="checkbox"/> 50mg <input type="checkbox"/> PO / <input type="checkbox"/> IV
<input type="checkbox"/> other: _____
ADDITIONAL PRE-MEDICATION ORDERS
<input type="checkbox"/> cetirizine (Zyrtec) 10mg PO
<input type="checkbox"/> loratadine (Claritin) 10mg PO
<input type="checkbox"/> Other: _____

REQUIRED DOCUMENTATION CHECKLIST:
<input type="checkbox"/> _____ Patient Demographics
<input type="checkbox"/> _____ Insurance Card/Information
<input type="checkbox"/> _____ Recent Progress note
<input type="checkbox"/> _____ Recent labsto include Hepatitis panel, CBC, CMP as well quantitative, if available. *Please send any other recent labs
_____ Other

LABORATORY ORDERS
<input type="checkbox"/> CBC <input type="checkbox"/> at each dose <input type="checkbox"/> every _____
<input type="checkbox"/> CMP <input type="checkbox"/> at each dose <input type="checkbox"/> every _____
<input type="checkbox"/> CRP <input type="checkbox"/> at each dose <input type="checkbox"/> every _____
<input type="checkbox"/> Other: _____
THERAPY ADMINISTRATION
Please check preferred product:
<input type="checkbox"/> Rituximab(Rituxan) <input type="checkbox"/> Rituximababbs (Truxima)
<input type="checkbox"/> Rituximab-pvvr (Ruxience)
<input type="checkbox"/> Dose: <input type="checkbox"/> 1000mg OR _____ mg OR _____ mg/kg
FREQUENCY:
<input type="checkbox"/> On Week 0 THEN WEEK 2;
<input type="checkbox"/> NO refills OR repeat series every:
<input type="checkbox"/> 16 Weeks
<input type="checkbox"/> 24 Weeks
<input type="checkbox"/> 26 Weeks
<input type="checkbox"/> Weekly x _____ TOTAL doses
<input type="checkbox"/> 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 _____