

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

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

**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

**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

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



**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

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

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)    Rituximababbs (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 \_\_\_\_\_