Westerville
575 Copeland Mill Road
Suite# 2F
Westerville, Ohio 43081

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

Lancaster
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

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 ______________