

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



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

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 _____