

RITUXIMAB ORDER FORM

Date: _____	ICD-10 Code: _____
Patient Name: _____	Allergies: _____
Date of Birth: _____	Weight: _____ lbs OR _____ kg

Therapy Status	Provider Information
<input type="checkbox"/> New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____	Ordering Provider: _____ Provider NPI: _____ Provider Phone: _____ Provider Fax: _____ Provider Address: _____

MEDICATION ORDER

<input type="checkbox"/> Rituximab _____ <i>Please Specify: Rituxan, Ruxience or Truxima if desired**</i>	<input type="checkbox"/> Administer 1,000mg IV on day 1 and day 15 per protocol. Repeat course every _____ weeks. <input type="checkbox"/> Administer _____ mg IV to be given per protocol every _____ weeks. <input checked="" type="checkbox"/> Pre-medications will be given as indicated below unless otherwise specified. Antihistamine dosage and route to be determined by on site provider.	Refills x one year from date of signature unless indicated below. <input type="checkbox"/> _____ Refills	<i>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</i> <input checked="" type="checkbox"/> Hepatitis B Surface Antigen. <input checked="" type="checkbox"/> Hepatitis B Core Antibody.
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PRE-MEDICATIONS

****To be given 30-60 minutes prior to infusion****

Oral	IV
<input checked="" type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg <input checked="" type="checkbox"/> 650mg <input type="checkbox"/> Loratadine: _____ 10mg <input type="checkbox"/> Cetirizine: _____ 10mg <input checked="" type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	<input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input checked="" type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input checked="" type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: _____ 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)	OTHER REQUIRED DOCUMENTATION
Surveillance lab ordering and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 800-223-4063) <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written: _____ Prescriber Name _____ Date _____	Substitution Allowed: _____ Prescriber Name _____ Date _____
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