

# TwelveStone Health Partners

Fax Referral To: (615) 278-3355

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## RITUXIMAB ORDER FORM

Date: \_\_\_\_\_

ICD-10 Code: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Allergies: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs OR \_\_\_\_\_ kg

**Therapy Status**

New Start

Continuing Therapy:  
Last Dose: \_\_\_\_\_

**Provider Information**

Ordering Provider: \_\_\_\_\_

Provider NPI: \_\_\_\_\_

Provider Phone: \_\_\_\_\_

Provider Fax: \_\_\_\_\_

Provider Address: \_\_\_\_\_

## MEDICATION ORDER

<p><b>Rituximab</b></p> <p>_____</p> <p><i>Please Specify: Rituxan, Ruxience or Truxima if desired**</i></p>	<p><input type="checkbox"/> Administer 1,000mg IV on day 1 and day 15 per protocol. Repeat course every _____ weeks.</p> <p><input type="checkbox"/> Administer _____ mg IV to be given per protocol every _____ weeks.</p> <p><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.</p>	<p>Refills for one year from date of signature unless indicated below.</p> <p>_____ Refills</p>	<p><b>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</b></p> <p><input checked="" type="checkbox"/> Hepatitis B Surface Antigen.</p> <p><input checked="" type="checkbox"/> Hepatitis B Core Antibody, Total (Not IgM)</p>
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## PRE-MEDICATIONS

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

<p><b>Oral</b></p> <p><input checked="" type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg <input checked="" type="checkbox"/> 650mg</p> <p><input type="checkbox"/> Loratadine: _____ 10mg</p> <p><input type="checkbox"/> Cetirizine: _____ 10mg</p> <p><input checked="" type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg</p> <p><input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg</p> <p><input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg</p> <p><input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg</p> <p><input type="checkbox"/> Other: _____</p>	<p><b>IV</b></p> <p><input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg</p> <p><input checked="" type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg</p> <p><input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg</p> <p><input checked="" type="checkbox"/> Methylprednisolone: 125mg</p> <p><input type="checkbox"/> Hydrocortisone: _____ 100mg</p> <p><input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg</p> <p><input type="checkbox"/> Other: _____</p>
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## LAB ORDERS (please indicate any labs to be drawn and frequency) OTHER REQUIRED DOCUMENTATION

<p><b>**Surveillance lab ordering and monitoring is the responsibility of the prescriber**</b></p>	<p>(Please fax this signed order form, along with the following documents to 800-223-4063)</p> <ul style="list-style-type: none"> <li>• History &amp; Physical, Last Office Visit Note</li> <li>• Patient Demographics and Insurance Information</li> <li>• Medication List</li> <li>• Recent Lab Work</li> </ul>
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**By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

*By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.*

<p>Dispense as Written:</p> <p>_____</p> <p>Prescriber Name _____ Date _____</p>	<p>Substitution Allowed:</p> <p>_____</p> <p>Prescriber Name _____ Date _____</p>
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