Rituxan

Provider Order Form

PATIENT INFORMATION

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Address: City: State: Zip Code:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

☐ NKDA ☐ Allergies: Weight lbs/kg: Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Last infusion date (if applicable):

REQUIRED DOCUMENTATION

☐ Labs (Hep B Test) ☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

ICD-10 CODE

☐ C85.90 Non-Hodgkin lymphoma, unspecified, unspecified site

☐ C91.10 Chronic lymphocytic leukemia

☐ M06.9 Rheumatoid Arthritis

☐ M31.30 Granulomatosis with Polyangitis (GPA) (Wegener's granulomatosis)

☐ M31.7 Microscopic Polyangitis (MPA)

☐ Other: _____

PRE-MEDICATION ORDER

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

Cetirizine (Zyrtec) ☐ 10mg PO

Loratadine (Claritin) ☐ 10mg PO

Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

Methylprednisolone (Solu-Medrol) ☐ 40mg IV ☐ 125mg IV

Hydrocortisone (Solu-Cortef) ☐ 100mg IV

Other: _____ Dose:_____ Route:_____ Frequency: _____

MEDICATION ORDER

No brand preference. Health Infusion Services will select product based on payer policy ☐ Brand preference: _____

Dose:

☐ 1,000mg IV

☐ 375mg/m2 IV

☐ Other: _____ mg IV

Frequency:

☐ Administer on Day 0 and Day 14; repeat series (2 doses separated by 2 weeks) every 24 weeks

☐ Administer on Day 0 and Day 14; repeat series (2 doses separated by 2 weeks) every _____ weeks

☐ Once weekly for 4 weeks

☐ Other: _____

☐ Access/De-access PICC/port per AleraCare protocol ☐ Do NOT administer heparin to this patient

PROVIDER INFORMATION

Provider Name: Provider Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

SPECIAL INSTRUCTIONS

Provider Name **Provider Signature** **Date** ☐ **Check here if this is a stat order**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

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