☐ *Borough Park*
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ *Crown Heights*
555 Lefferts Avenue
Brooklyn, NY 11225

☐ *Manhattan*
57W 57Street
Suite 601
New York, NY 10019

☐ *Manhasset*
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ *Rockville Centre*
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ *Elmsford/ Terrytown*
555 Taxter Road
3rd Floor
Elmsford, NY 10523

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

Mission Medical

☐ *Manhattan*
225 E 70th Street
Suite 1E
New York, NY 10021

☐ *Holbrook/ Ronkonkoma*
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ *Long Beach*
917 Beech Street
Long Beach, NY 11561

☐ *Queens*
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ *Scarsdale*
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

☐ *Riverhead*
1228 E Main Street
Suite A
Riverhead, NY 11901

☐ *Manhattan*
225 East 70th Street
New York, NY 10021

☐ *5 Towns*
141 Washington Avenue
Cedarhurst, NY 11559

(rituximab)

# RITUXAN infusion orders

**Date:** _____

Patient Name _____ DOB _____

Phone _____ ◯ Allergies _____ M◯ F◯

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

## REFERRAL STATUS

☐ New Prescription
☐ Order Renewal
☐ Does or Frequency Change
☐ Discontinuation

## DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Rheumatoid Arthritis
☐ _____ Granulomatosis w/Polyangitis
*(wegener's granulomatosis GPA)*

☐ _____ Microscopic Polyangitis
☐ _____ _____
*(other)*

## PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ _____

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____

## RITUXAN ORDERS

### DOSAGE

◯ 1000mg
◯ 375mg/m²
◯ Other _____

### PATIENT WEIGHT

_____ lbs.
_____ kg

### FREQUENCY

◯ intial dose (0) followed by 2nd dose on day 15 *(induction for RA diagnosis)*
◯ single dose
◯ every week for 4 weeks total
◯ _____
*(other frequency)*

◯ Total dosages _____
◯ Refills _____

## NOTES

_____

## ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____