Princeton / Somerset New Jersey 49 Veronica Avenue Suite 202 Somerset, NJ 08873





Provider Order Form Rituximab (Rituxan, Truxima, Ruxience)

Name: DOB: Date of Referral: Date of Referral Coordinator: Date of Referral Coordinator: Date of Referral: Date	PA	TIENT IN	FORMATION
CD-10 code (required): ICD-10 description: Weight lbs/kg:		I	
DNKDA Allergies:	Allergies:		Date of Referral: .
Patient Status: New to Therapy Continuing Therapy Next Due Date (if applicable): PROVIDER INFORMATION	ICD-10 code (required):	ICD -10 de	escription:
Referral Coordinator Name: Referral Coordinator Email: Ordering Provider: Provider NPI: Referring Practice Name: Phone: Fax: Practice Address: City: State: Zip Code: REFERRAL STATUS LABORATORY ORDERS Order Renewal Core Address: City: State: Zip Code: CRP At each dose Levery Core CMP Address: Core CMP Address: Core CMP Address: Core CMP Address:	<u> </u>		<u> </u>
Referral Coordinator Name: Referral Coordinator Email: Ordering Provider: Provider NPI: Referring Practice Name: Phone: Fax: Practice Address: City: State: Zip Code: REFERRAL STATUS New Prescription Corrections City: State: Zip Code: CBC	Patient Status: ☐ New to Therapy ☐ Continuing Therap	oy Next Due	Date (if applicable):
Ordering Provider: Referring Practice Name: Phone: Fax: Practice Address: City: State: Zip Code: REFERRAL STATUS New Prescription Order Renewal Obes or Frequency Change Discontinuation PRE-MEDICATION ORDERS The following are manufacturer recommended premedication regimens: a cataminophen (Tylenol) \(\text{DSOmg} \) / \(DSOmg	P	ROVIDER IN	FORMATION
Referring Practice Name: Phone: Fax: Practice Address: City: State: Zip Code: REFERRAL STATUS New Prescription Order Renewal Does or Frequency Change Discontinuation PRE-MEDICATION ORDERS The following are manufacturer recommended premedication regimens: acetaminophen (Tylenol) ID500mg / ID5000mg / ID500mg / I	Referral Coordinator Name:	Referral Co	oordinator Email:
Practice Address: City: State: Zip Code:	Ordering Provider:	Provider N	PI:
REFERRAL STATUS New Prescription	Referring Practice Name:	Phone:	Fax:
O New Prescription Order Renewal Obes or Frequency Change Discontinuation PRE-MEDICATION ORDERS The following are manufacturer recommended premedication regimens: acetaminophen (Tylenol) □500mg /□650mg /□1000mg PO methylprednisolone (Solu-Medrol) □40mg /□125mg ∨ diphenhydramine (Benadryl) □25mg /□50mg □PO /□IV other Other Other Other: Dose: □ Route: □ Other: □ Infusion in series: 50mg/hr, increase every 24 weeks Other: □ Pre-medicate patients with an antihistamine and acetaminophen prior to dosing. For RA and PV patients, methylprednisolone 100 mg intravenously or its equiverecommended 30 minutes prior to each infusion. Screen all patients for HBV infection by measuring HBsAg negative but anti-HBc before initiating treat ment with RTU. Pre-medicate patients with an antihistamine and acetaminophen prior to dosing. For RA and PV patients, methylprednisolone 100 mg intravenously or its equiverecommended 30 minutes prior to each infusion. Screen all patients for HBV infection by measuring HBsAg and anti-HBc before initiating treat ment with RTU. Pre-medicate patients with an antihistamine and acetaminophen prior to dosing. For RA and PV patients, methylprednisolone 100 mg intravenously or its equiverecommended 30 minutes prior to each infusion. Screen all patients for HBV infection by measuring HBsAg and anti-HBc before initiating treat ment with RTU. Pre-medicate patients with an antihistamine and acetaminophen prior to dosing. For RA and PV patients, methylprednisolone 100 mg intravenously or its equiverecommended 30 minutes prior to each infusion. Screen all patients for HBV infection by measuring HBsAg and anti-HBc before initiating treat ment with RTU. Pre-medicate patients with an antihistamine and acetaminophen prior to dosing. For RA and PV patients, methylprednisolone 100 mg intravenously or its equiverecommended 30 minutes prior to each infusion. Screen all patients for HBV infection by measuring HBsAg and anti-HBc before initiating treat ment with RTU. Pre-medicate patients with an antihist	Practice Address:	City:	State: Zip Code:
O New Prescription Order Renewal O Does or Frequency Change O Discontinuation PRE-MEDICATION ORDERS The following are manufacturer recommended premedication regimens: acetaminophen (Tylenol) □500mg / □650mg / □1000mg PO □ methylprednisolone (Solu-Medrol) □40mg / □125mg V □ diphenhydramine (Benadryl) □25mg / □50mg □PO / □IV □ other □ ADDITIONAL PRE -MEDICATION ORDERS □ cetirizine (Zyrtec) 10mg PO □ ortadaine (Claritin) 10mg PO	REFERRAL STATUS		LABORATORY ORDERS
The following are manufacturer recommended premedication regimens: acetaminophen (Tylenol) □500mg / □650mg / □1000mg PO methylprednisolone (Solu-Medrol) □40mg / □125mg IV diphenhydramine (Benadryl) □25mg / □50mg □PO / □IV other	Order RenewalDoes or Frequency Change		☐ CMP ☐ at each dose ☐ every ☐ CRP ☐ at each dose ☐ every
For patients who show evidence of prior hepatitis B infection (HBsAg positive [regardless of antibody status] or HBsAg negative but antiHBc positive), consult with physicians with expertise in managing hepatitis B regarding monitoring and consideration for HBV antiviral therapy before and/or during RITUXAN treatment. ORDERING PROVIDER	The following are manufacturer recommended premedication regimens: □ acetaminophen (Tylenol) □500mg / □650mg / □1000mg PO □ methylprednisolone (Solu-Medrol) □40mg / □125mg IV □ diphenhydramine (Benadryl) □25mg / □50mg □PO / □IV □ other ADDITIONAL PRE -MEDICATION ORDERS □ cetirizine (Zyrtec) 10mg PO □ loratadine (Claritin) 10mg PO □ Other: Dose: Route: Frequency:		Please check preferred product: □ Rituximab(Rituxan) □ Rituximababbs (Truxima) □ Rituximabpvvr (Ruxience) ☑ Mix in 0.9% sodium chloride or D5W to final concentration of 1 4mg/ml ■ Dose:□ 1000mg /□mg □ mg / kg ■ Mix in:□ 500ml /□ 250ml □ other ■ Frequency:□ On Series Day 0 and Series Day 14; repeat series every 24 weeks □ Other: ■ Infusion rate: First infusion in series: 50mg/hr, increasing every 30 minutes by 50mg/hr to maximum of 400mg/hr ■ Subsequent infusion in series: 100mg/hr, increasing every 30 minutes by 100mg/hr to maximum of 400mg ☑ Flush with 0.9% sodium chloride at the completion of infusion ☑ Monitor patient for 30 minutes post infusion □ Refills:□ Zero /□ for 12 months /□ (if not indicated order will expire one year from date signed) □ total dosage □ refill
	For patients who show evidence of prior hepatitis B infection (HBsA physicians with expertise in managing hepatitis B regarding monitor ORDERING PROVIDER	g positive [regardl ing a nd considera	ess of antibody status] or HBsAg negative but antiHBc positive), consult with ation for HBV antiviral therapy before and/or during RITUXAN treatment.
Provider Fax			