Cumberland Vital Care

Fax Referral To:
(931) 456-4857

Direct Phone: (931) 456-0680

RITUXIMAB ORDER FORM

Date: ______________	ICD-10 Code: ______________
Patient Name: ______________	Allergies: ______________
Date of Birth: ______________	Weight: ________lbs OR ________kg

Therapy Status	Provider Information
☐ New Start ☐ Continuing Therapy: Last Dose: ______________	Ordering Provider: ______________ Provider NPI: ______________ Provider Phone: ______________ Provider Fax: ______________ Provider Address: ______________

MEDICATION ORDER

☐ Rituximab ______________ *Please Specify:* Rituxan, Ruxience or Truxima if desired**	☐ Administer 1,000mg IV on day 1and day 15 per protocol. Repeat course every _______ weeks. ☐ Administer _______ mg IV to be given per protocol every _______ weeks. ✓ 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. ☐ ________Refills	***Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:*** ✓ Hepatitis B Surface Antigen. ✓ Hebatitis B Core Antibody Total (Not Core IgM).

PRE-MEDICATIONS

To be given 30-60 minutes prior to infusion

Oral

✓ Acetaminophen: _______325mg _______500mg ___X___650mg
☐ Loratadine: ______10mg
☐ Cetirizine: ______10mg
✓ Diphenhydramine: _______25mg _______50mg
☐ Famotidine: _______20mg _______40mg
☐ Ibuprofen: _______200mg _______400mg _______600mg
☐ Ondansetron: _______4mg _______8mg
☐ Other: ______________

IV

☐ Dexamethasone: _______4mg _______8mg
✓ Diphenhydramine: _______25mg _______50mg
☐ Famotidine: _______20mg _______40mg
✓ Methylprednisolone: 125mg
☐ Hydrocortisone: _______100mg
☐ Ondansetron: _______4mg _______8mg
☐ Other: ______________

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Ofice 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:	Substitution Allowed:
______________ Prescriber Name ________ Date	______________ Prescriber Name ________ Date