Rituxan (rituximab)

Provider Order Form rev. 5/20/2022

AleraCare
A Healthcare Solutions Company
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PATIENT INFORMATION

Patient Name: DOB:

Patient Phone: Patient Email:

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

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

DOCUMENTATION (REQUIRED)

☐ Labs ☐ 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 ORDERS (given 30 min before each infusion)

☐ Methylprednisolone 100mg IV and (select acetaminophen and antihistamine doses below)

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

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg / ☐ PO ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mgIV ☐ 125mg IV

☐ hydrocortisone (Solu-Cortef) 100mg IV

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

MEDICATION ORDER

Rituxan (rituximab)

Dose:

☐ 1,000 mg 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

☐ Other:_____

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

☐ **Check here if this is a stat order**