aleracare
advanced infusion centers™

FAX 833.329.4738

Rituxan (rituximab)

Provider Order Form rev. 5/5/2023

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

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

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

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

Documentation Required (Note: Send all labs, must include specific labs listed here)

◯ 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 *(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) ◯ 40mg IV ◯ 125mg IV

hydrocortisone (Solu-Cortef) ◯ 100mg IV

Other: _____

Dose:_____ Route:_____ Frequency: _____

Medication Order

Rituxan (rituximab)

Dose: ◯ 1,000mg 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: _____

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

_____

Provider Name _____ **Provider Signature** _____ **Date** _____

Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order ◯