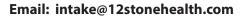
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





RITUXIMAB ORDER FORM					
Date:		ICE	ICD-10 Code:		
Patient Name:		Alle	Allergies:		
Date of Birth:		We	eight:lbs OR	kg	
Therapy Status			Provider Information		
		Ord	Ordering Provider:		
□ New Start		Pro	Provider NPI:		
I— 1 11 1			Provider Phone:		
☐ Continuing Therapy:			Provider Fax:		
Last Dose:					
		Pro	Provider Address:		
MEDICATION ORDER					
Rituximab	Administer 1,000mg IV on day 1and day 15 per protocol. Repeat course every weeks		Refills for one year from date of signature unless indicated below.	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:	
Please Specify: Rituxan,	protocol every weeks.				
Ruxience or	✓ Pre-medications will be given as indicated belo		Refills	✓ Hepatitis B Surface Antigen.	
Truxima if desired**	unless otherwise specified. Antihistamine dosa and route to be determined by on site provider.	_		√ Hepatitis B Core Antibody, Total (Not IgM)	
<u> </u>			TIONS	(1101.19.11)	
PRE-MEDICATIONS **To be given 30-60 minutes prior to infusion**					
Oral ✓ Acetaminophen:325mg500mg _ X650mg IV Dexamethasone:4mg8mg				8mg	
☐ Loratadine: 10mg			✓ Diphenhydramine:25mg50mg		
☐ Cetirizine:10mg			☐ Famotidine: 20mg40mg		
✓ Diphenhydramine: 25mg 50mg			✓ Methylprednisolone: 125mg		
☐ Famotidine: 20mg40mg			☐ Hydrocortisone:100mg		
☐ Ibuprofen: 200mg400mg600mg			☐ Ondansetron: 4mg 8mg		
☐ Ondansetron:4mg8mg			☐ Other:		
Other:					
LAB ORDERS (please indicate any labs to be drawn and frequency)			OTHER REQUIRED DOCUMENTATION		
Surveillance lab ordering and monitoring is the responsibility of the prescriber			 (Please fax this signed order form, along with the following documents to 800-223-4063) History & Physical, Last Office 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 (S/GN BELOW)					
By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.					
Dispense as Written:		Τ.	Substitution Allowed:		
Prescriber Signature	 	_ Pr	rescriber Signature	 Date	